DOCUMENT RESUME

ED 408 780 EC 305 441

AUTHOR	Reid, Jennifer; And Others
TITLE	The Role of Speech & Language Therapists in the Education of Pupils with Special Educational Needs. Final Report to the Scottish Office Education & Industry Department.
INSTITUTION	Edinburgh Univ. (Scotland).
SPONS AGENCY	Scottish Office Education and Industry Dept., Edinburgh.
REPORT NO	ISBN-0-9529067-4-2
PUB DATE	96
NOTE	263p.
AVAILABLE FROM	SLT Project, Dept. of Psychology, University of Edinburgh, 7 George Square, Edinburgh, Scotland EH8 9JZ, United Kingdom (14 British pounds).
PUB TYPE	Reports - Descriptive (141) -- Tests/Questionnaires (160)
EDRS PRICE	MF01/PC11 Plus Postage.
DESCRIPTORS	*Communication Disorders; *Delivery Systems; Educational Resources; Elementary Secondary Education; Foreign Countries; Inclusive Schools; Integrated Services; Intervention; Parent Participation; *Parent School Relationship; Preschool Children; Program Effectiveness; *Speech Language Pathology; Student Needs; *Teacher Collaboration; Therapists
IDENTIFIERS	*Scotland

ABSTRACT

A 3-year study of 12 regional and 3 island authorities in Scotland investigated: (1) the speech and language therapy needs of pupils with special education needs; (2) forms of collaboration among parents and professionals; and (3) the perceived effectiveness of different models of speech and language therapy service delivery. The research results included the following findings: (1) there is a pattern of ever increasing demand for speech and language therapy that continuously outstrips increases in provision; (2) speech and language therapy managers felt that they had lost the power to give priority to children who did not have Records of Needs but who had equally pressing needs for speech and language therapy; (3) speech and language therapy managers felt services to pre-school children were increasingly at risk because of the reallocation of resources to school-aged children; (4) effective provision of speech and language therapy to pupils in mainstream schools has not yet been achieved; (5) provision of speech and language therapy is reported by parents and professionals to be especially poor at the secondary school level; and (6) collaborative practices were found in both mainstream and special educational settings, but particularly in evidence in special educational facilities. (Contains 36 references.) (CR)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

ED 408 780

The Role of Speech & Language Therapists in the Education of Pupils with Special Educational Needs

Jennifer Reid, Sally Millar, Louise Tait,
Morag L Donaldson, Elizabeth C Dean,
George O B Thomson and Robert Grieve.

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

☑ This document has been reproduced as received from the person or organization originating it.

☐ Minor changes have been made to improve reproduction quality.

• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

PERMISSION TO REPRODUCE AND DISSEMINATE THIS MATERIAL HAS BEEN GRANTED BY

M.L. - Donaldson

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

BEST COPY AVAILABLE

Edinburgh Centre for Research in Child Development

EC 305 661

The Role of Speech & Language Therapists in the Education of Pupils with Special Educational Needs

Final Report to the Scottish Office Education & Industry Department

Jennifer Reid, Sally Millar, Louise Tait,

Morag L Donaldson, Elizabeth C Dean,

George O B Thomson and Robert Grieve.

Departments of Psychology and Education, The University of Edinburgh
Department of Speech & Language Sciences, Queen Margaret College, Edinburgh

Edinburgh Centre for Research in Child Development

1996

© J Reid, S Millar, L Tait, M L Donaldson, E C Dean, G O B Thomson, R Grieve 1996

ISBN 0 9520667 4 2

ECRCD Publications

Contents

ACKNOWLEDGEMENTS iv

GLOSSARY v

EXECUTIVE SUMMARY vi

INTRODUCTION AND OVERVIEW

- Introduction 1
- Multidisciplinary approaches to speech, language and communication problems 1
- Aims of the research 2
- Structure of the report 2

CHAPTER 1

Background and Recent Developments 4
- Introduction 4
- Speech and language therapy 4
  - Speech & language therapists: roles and qualifications 4
  - How are speech & language therapy services organised? 5
  - How do people gain access to speech & language therapy? 6
- Assessing speech & language therapy needs 6
  - Differing perspectives 6
  - The scale of speech & language therapy needs 7
  - Rising demands on speech & language therapy services 8
  - The changing role of speech & language therapists 8
  - Speech & language therapy: a professional framework 9
  - Identifying individual needs and planning intervention 10
- Special educational needs 12
  - Changing views and legislation 12
  - Records of needs 13
  - Partnership with parents 13
  - Responsibility for provision of speech and language therapy 14
- New arrangements for speech and language therapy services in education 14
- Special educational needs and the curriculum 16

Summary 17

CHAPTER 2

Methodology 18
- Introduction 18
- Data Collection 18
  - Postal questionnaires 18
  - Visits 23
  - Additional consultations 24
- Data analysis 24
- Presentation 24

Summary 25

CHAPTER 3

Speech & language therapy in Scotland: 26
- Introduction 26
- Speech & language therapists working in Scotland 26

Speech & language therapy provision in schools 27
Children and young people receiving a speech & language therapy service in different categories of location 28
Children and young people with and without Records of Needs receiving a speech & language therapy service 29
Children and young people receiving a speech & language therapy service: gender, age and geographical area 30
Prioritisation of caseloads....................31
How speech & language therapists work and collaborate in different types of school 32
A framework for describing how speech & language therapists work in different types of schools 34
Mainstream nursery schools and classes....................36
Mainstream primary schools....................38
Mainstream secondary schools....................41
Special educational facilities for pupils with learning difficulties 44
Special educational facilities for pupils with specific language disorder ('language units/classes')....................49
Special educational facilities for pupils with pervasive communication disorder (including autism) 51
Special educational facilities for pupils with hearing impairment 53
Special educational facilities for pupils with physical disabilities....................55
Special educational facilities for pupils with visual impairment 57
Special educational facilities for pupils with emotional and behavioural difficulties 57
How speech & language therapists work and collaborate: comparisons across different types of educational facility 57
Summary and discussion 60

CHAPTER 4

Speech & language therapy in schools: case studies....................62
Introduction....................62
Case Study A:....................64
The speech & language therapist's perspective....................65
The school's perspective....................66
Differences in perspective....................68
Case Study B:....................69
Summary....................72

CHAPTER 5

Speech & language therapy provision: policy issues 73
Introduction....................73
Implementing the Secretary of State's (1991) Initiative 73
Recruitment and retention of speech & language therapists....................74
Integration into mainstream schools of pupils with special educational needs 75
Issues relating to Records of Needs 77
Speech & language therapy for pre-school and other children without Records of Needs....................79
Speech & language therapy in mainstream secondary schools 80
Speech & language therapy for hearing-impaired pupils....................81
Other challenges for speech & language therapy services....................81
Should speech & language therapists be employed by education rather than health?....................81
An educational analysis of speech & language therapy needs 84
Summary and conclusions....................89

CHAPTER 6

What makes for effective collaboration? 90
  What is 'effectiveness' in speech & language therapy terms? 90
    What do parents think about speech & language therapy? 91
  Collaboration, joint working and working alone 93
  Effective collaboration 95
  Barriers to collaboration 97
  Collaboration in Scotland in the 1990s 99
    Do teachers, SLTs and parents understand and respect each others roles? 99
    Understanding what speech & language therapists do 99
    Understanding what teachers do 101
    Do parents feel they are part of the process of collaboration? 102
    How do parents view collaboration between professionals? 103
Summary and conclusions 104

CHAPTER 7

The way forward 105
  Is there still an overall need for more resources for speech & language therapy services in education? 105
  The organisation of speech & language therapy services to education 106
  Effective collaboration 107
  Developments in the curriculum 118
  Educational support for pupils with speech, language & communication difficulties 118
  Advancing the professional development of teachers and SLTs working with pupils with speech, language and communication difficulties 121
Summary and conclusions 123

References 124

Appendices 127

ACKNOWLEDGEMENTS

We should like to thank the Scottish Office Education and Industry Department for commissioning and funding this project. We were grateful for the enthusiasm, support and encouragement we received from our Advisory Committee, and particular thanks are due to those individual members of the Committee who provided us with practical assistance during the time of the study. However, our most heartfelt thanks are reserved for the participants in the study, parents, speech & language therapists and their managers, teachers, advisers in special educational needs and educational psychologists and others. We thank those who filled in our questionnaires, the head teachers who allowed us access to staff and parents, and especially those whom we interviewed; not only were they generous with their time but the study gained a great deal from their frank and insightful answers. Last but by no means least, we are indebted to speech & language therapy managers who not only collected a great deal of information but also helped with distribution of questionnaires and organisation of visits and interviews.

GLOSSARY

The glossary shown below was included in each of the questionnaires used for data collection in this project. It is reproduced here as a summary of the terminological conventions which have been adopted throughout this report.

For the purposes of this report:

A speech, language or communication problem is one that interferes with learning and/or participation in the educational process, and in this sense it gives rise to special educational needs.

Communication is the process by which information, ideas and emotions are exchanged. While information and ideas are communicated primarily through language, emotions are usually communicated through touch, gesture, eye gaze, facial expression and other aspects of 'body language'. Communication is fundamental to the establishment and maintenance of relationships, and to participation in social and educational situations.

People with good speech and language can nonetheless be poor communicators, just as people with poor speech and/or language can be quite good communicators.

Language is any system of vocabulary and grammar. Such systems include speech, written words, manual signs and computer codes. Language is used for formulating thought and, in communication, for conveying and understanding meanings.

As language plays a fundamental role in thinking, remembering and reasoning, it is also essential for learning.

Speech is language in its spoken form. In other words, speech is not possible without language.

The ability to produce speech is not limited to physically making sounds but also includes the underlying mental processes involved in learning, remembering and reproducing the words of any language.

The following abbreviations are used in this report:

AAC	Alternative and augmentative communication (e.g. computerised speech output device, symbol chart or manual signing)
AHT	Assistant head teacher
IEP	Individualised educational programme
ISD	Information & Statistics Division (of the Scottish Health Service Common Service Agency)
LST	Learning support teacher
(R)CSLT	(Royal) College of Speech & Language Therapists
SLT	Speech & language therapist
S(O)ED	Scottish (Office) Education Department
S(O)HHD	Scottish (Office) Home and Health Department
WTE	Whole-time equivalent (posts)

EXECUTIVE SUMMARY

Introduction

The delivery of speech & language therapy services to children and young people with speech, language and communication difficulties has become a focus of great interest among parents and professionals in recent years.

This report describes the results of research, funded by the Scottish Office Education Department, which was completed by researchers at the University of Edinburgh and Queen Margaret College, Edinburgh. The aims of the project were to study:

(i) the speech & language therapy needs of pupils with special educational needs

(ii) forms of collaboration among parents and professionals, and

(iii) the perceived effectiveness of different models of speech & language therapy service delivery.

The research covered the twelve regional and three island authorities in Scotland prior to April 1996. The study represents the first attempt to evaluate systematically the needs of children and young people, and the needs, perceptions and expectations of parents, teachers, speech & language therapists (SLTs) and other professionals concerned with the provision of speech & language therapy in an educational context.

Methodology

Data were obtained from a series of postal questionnaires, school visits and interviews carried out between December 1993 and April 1995. The questionnaires elicited quantitative and qualitative data, and were sent to speech & language therapy managers, speech & language therapists, teachers, principal and divisional educational psychologists, advisors in special education, and parents. The response rate was very good for all groups with the exception of educational psychologists. Twenty visits were carried out to educational settings which represented a range of educational and geographical contexts. 81 individuals were interviewed including head teachers, class teachers, learning support teachers, classroom auxiliaries, parents and speech & language therapists.

Speech & Language Therapy in Scotland, 1993-1995

Background

Health boards have been and continue to be the major purchasers of speech & language therapy services. Education authorities purchase speech & language therapy services for some children with Records of Needs. Other purchasers include GP fund holders.

Speech & language therapy services are currently provided by NHS Trusts or, in the Western and Northern Islands, health boards. A few SLTs are employed by voluntary agencies or work independently. While some SLTs work largely with adults, the majority work exclusively or mainly with children and young people.

Individual parents of children with speech, language and communication difficulties, and voluntary groups have voiced concern about the provision of speech & language therapy.

Evidence

Questionnaires returned by speech & language therapy managers indicated that in Scotland as at 31 March 1993:

- 662 speech & language therapists were employed within the NHS sector; an increase of 205 posts since 1990.
- There were 13 SLTs per 100,000 population. This is 100% greater than the recommendations of the 'Quirk Report' (Committee of Enquiry into the Speech Therapy Services, 1972) but 50% below the standard proposed by Enderby and Davies (1989).
- 9% of speech & language therapy posts were vacant.
- Since 1990, there has been an overall increase in ***on-site provision*** of speech & language therapy to mainstream and special educational facilities.
- A significant number of educational facilities required but did not receive on-site therapy, based on standards developed by a working group of the National Paramedical Committee (SOHHD, 1993).
- There is a pattern of ever-increasing demand for speech & language therapy which continuously outstrips increases in provision.

Government sources record that:

- Over 68,000 people were seen by SLTs in 1993/94. This represents a 10% increase over the previous year, and is over 83% more than in 1982/83 (ISD Scottish Health Service Common Service Agency, 1995).

Comment

Although there have been overall increases in provision, it cannot be inferred that all speech & language therapy needs are being met. Further, the figures do not address the issue of whether children and young people receiving speech & language therapy are receiving the most appropriate quantity or quality of service.

Speech & Language Therapy For Children And Young People

Background

In 1991, the Secretary of State for Scotland introduced changes to the way in which speech & language therapy services were to be delivered to pre-school and school-aged children with Records of Needs. The primary intention of this initiative was to enable education authorities to have direct control over the financial resources required to discharge their statutory duties towards children with Records of Needs.

There has been increasing recognition that speech & language therapy needs are diverse and may not be best met through focusing exclusively on the individual child/young person. The importance of a collaborative management strategy involving parents and other professionals is now accepted (CSLT, 1991).

Evidence

- Questionnaire returns from speech & language therapy managers indicated that over 30,000 children and young people were within the speech & language therapy service on 31 March 1994.
- Speech & language therapy managers reported a professional emphasis on early identification and intervention and this was reflected in the finding that 39% of under-18 clients fell into the 0–4 year age band compared to only 9% in the 12–18 year age band.
- 15% of children and young people within the speech & language therapy service were known by speech & language therapy managers to have Records of Needs.
- The Secretary of State's (1991) initiative was reported by speech & language therapy managers and SLTs to have resulted in additional speech & language therapy posts, changes in the delivery of the speech & language therapy service to pupils in schools, and a re-allocation of resources in favour of school-aged children.
- Opening a Record of Needs was stated by some parents and professionals as being seen as a means of ensuring access to additional resources, including speech & language therapy services.
- According to speech & language therapy managers, not all speech & language therapy services to pupils with Records of Needs were funded through education contracts. Where education-funded resources were insufficient, provision had to be made from health-funding.
- Speech & language therapy managers felt that, because of their contractual duty towards children with a Record of Needs, they had lost the power to give priority to children who did not have Records of Needs but who had equally pressing needs for speech & language therapy. Managers felt services to pre-school children, including those with eating and drinking problems, were increasingly at risk because of the re-allocation of resources to school-aged children.

Speech & Language Therapy In Education

Background

Education authorities in Scotland have a duty to make provision for the special educational needs of all pupils with such needs. For some pupils Records of Needs will be drawn up by educational, health and social work professionals and parents.

It is now increasingly recognised that speech, language & communication difficulties in children/young people may not be effectively treated in isolation from their daily communication situations, such as those which are associated with the activities of classroom and school. The Royal College of Speech & Language Therapists' professional guidelines for good practice emphasise skill-sharing, flexible working practices and the integration of therapy and educational programmes (CSLT, 1991).

Evidence

- Effective provision of speech & language therapy to pupils in mainstream schools has not yet been achieved according to data from speech & language therapy managers and SLTs, and visits to schools.
- Provision of speech & language therapy is reported by parents and professionals to be especially poor at secondary school level.

- The survey results show that, particularly in mainstream schools, many SLTs continue to provide only a traditional, withdrawal-based style of therapy.

- The responses of those surveyed and interviewed indicated that poor understanding of the roles of other professionals may lead to false expectations of those professionals.

- Many parents and professionals reported that pupils benefit when speech & language therapy programmes are integrated with rather than kept separate from educational programmes.

- The project team found evidence of collaborative practice among SLTs, teachers and parents which was perceived as effective by participants. Collaborative practice was found in both mainstream and special educational settings but was particularly in evidence in special educational facilities.

Comment

Speech & language therapy needs do not appear to be met well by SLTs working in isolation. While withdrawal of pupils from class for speech & language therapy has a place within a range of approaches, withdrawal-based intervention should be viewed as one possible option rather than as 'the norm'.

The effectiveness of SLTs in schools will be enhanced by a shared understanding (among parents, education staff and SLTs) of the roles SLTs can play within educational settings.

The speech, language and communication difficulties of pupils with special educational needs, and the remediation and management of such difficulties, require to be viewed as educational issues, and not as the sole concern of the speech & language therapy service.

Collaboration requires shared understanding and the existence of appropriate resources, conditions which do not always apply in all schools.

The attitude and commitment of school staff to the speech, language and communication needs of pupils may be just as influential as the input of SLTs in meeting the needs of such pupils. Where effective innovative practice was found, the degree of commitment and effort on the part of the school was very striking.

The 5-14 Curriculum Guidelines may provide a starting point for a shared perspective for teachers and SLTs. However, to provide an effective shared framework, development of the Guidelines will be required in order to establish more relevant and detailed targets for pupils with speech, language and communication difficulties.

Education staff and SLTs need a shared framework for assessing pupils' speech & language therapy needs, for planning appropriate educational programmes, and for documenting and recording progress.

To facilitate interdisciplinary collaboration, differing perceptions and expectations need to be made explicit, and misperceptions cleared up. Issues that may need to be addressed include:

- **barriers between professions, vested interests and feelings of insecurity or jealousy**
- **fear of loss of autonomy**
- **different priorities or criteria of speech & language therapy 'need'**
- **different working conditions**
- **jargon**
- **lack of training in collaborative practices**

- cumbersome bureaucracy
- conflicting demands due to membership of several teams
- lack of 'team play'
- lack of time

Actions which may lead to better collaboration in the future include:

- education for teachers on speech, language and communication development
- more information about the speech & language therapy service in pre-service and professional development programmes for teachers
- more information about education in pre-service and professional development programmes for SLTs
- joint staff development opportunities for teachers and therapists
- formal arrangements and increased time for contact between SLTs and teachers
- joint assessment, goal setting and programme planning
- sharing of information
- integrated record keeping
- better mutual understanding by teachers, SLTs and classroom assistants of one another's conditions of service
- joint involvement at managerial level in the appointment of SLTs working in educational settings and of teaching staff in special educational facilities catering for pupils with speech, language and communication difficulties
- the setting in place by head teachers of mechanisms to ensure that SLTs feel part of the school

Conclusions: Future Developments

Facilitating collaboration

Effective provision for pupils with special educational needs including speech, language and communication difficulties is not only the responsibility of individual SLTs and teachers but also of managers, schools, local authorities and central government.

Service specifications and contracts between health and education for speech & language therapy services need to include provision for indirect aspects of therapy, for example, time for joint planning, as well as for direct therapy.

Education authorities need to find ways of ensuring that the input from SLTs, and collaboration between SLTs and other professionals, is well supported. Possible strategies include the provision of :

- more specialist language support teacher posts
- more support for, and access to, specialist education for language support teachers
- broadening of the role of learning support teachers, to include more collaboration with SLTs, and to be more involved in meeting the speech, language and communication needs of pupils in mainstream classes
- classroom assistants with special responsibility and training to carry out speech, language and communication programmes under the direction of teachers and SLTs
- more special educational facilities for pupils with speech, language and communication difficulties, either in the form of special units/classes, or in the form of greater availability of specialist support in mainstream settings

- more clinical placements within educational settings for undergraduate SLTs

Simple but formal school-level agreements between schools and SLTs could make explicit the expected contributions from both the school staff and SLTs as well as providing a basis for the monitoring and evaluation of provision for pupils with speech, language and communication difficulties.

Demands upon the speech & language therapy service

In the light of continuous increases in demand upon speech & language therapy services, there needs to be ongoing appraisal of how best to use available resources and additional funding.

Policy-makers and professionals within the areas of health and of education must co-operate to ensure that scarce resources are distributed most effectively and efficiently across those children/young people who may benefit from speech & language therapy services.

A mechanism is needed to ensure that funding accompanies any increases in the numbers of children/young people with Records of Needs who have a requirement for speech & language therapy

There needs to be an increased level of awareness about the nature and efficacy of the variety of models of speech & language therapy service delivery.

Systematic evaluation of the efficacy and the cost effectiveness of different models of service delivery, based on the data reported within this report, would inform decision making and management practices within the field of speech & language therapy for children with special educational needs.

INTRODUCTION AND OVERVIEW

Introduction

This document reports on the work of a research team at the University of Edinburgh and Queen Margaret College, Edinburgh operating under a research grant from the Scottish Office Education Department (SOED). The research, conducted from October 1993 to September 1995, investigated the role of speech & language therapists (SLTs) in the education of pupils with special educational needs.

The delivery of speech & language therapy services to children and young people with speech, language and communication problems has become a focus of great interest among parents and professionals in recent years. The contexts of this increased interest are many and varied. Amongst them are: parental concern over provision of speech & language therapy services; the changes in thinking, procedures and practices consequent upon the publication of the Warnock Report (Committee of Enquiry into the Education of Handicapped Children and Young People, 1978) and the resultant legislation in both Scotland and England & Wales implementing aspects of the Report; the Secretary of State for Scotland's Initiative in 1991 outlining new procedures for the funding and delivery of speech & language therapy services to pupils with Records of Needs; the awareness in the speech & language therapy profession of the need to establish, and communicate to a wider audience, its professional standards; the potential effects on service delivery of the reorganisation of local authorities from twelve island and regional authorities to twenty-nine unitary authorities, scheduled to come into effect on 1 April 1996. Further reference to the impact of the above initiatives will be made later in this report.

Multidisciplinary approaches to speech, language and communication problems

In recent years, there has been increasing recognition of the importance of collaboration amongst different types of professionals in assessing and meeting the needs of children with speech, language and communication problems. For example, in a survey of Language Units in Scotland (conducted by a working party of Scottish Principal Educational Psychologists in 1988), it was found that SLTs frequently expressed a desire to be more involved in working in the classroom, in collaboration with teachers. Similarly, in 1991, the College of Speech & Language Therapists (now the Royal College of Speech & Language Therapists) published a set of professional guidelines which places considerable emphasis on multidisciplinary, multi-agency approaches to assessment and intervention (CSLT, 1991). The justification for adopting such approaches is based not only on the evidence that speech, language and communication problems often co-occur with other problems, but also on the argument that the effectiveness of interventions for speech, language and communication problems can be enhanced by integrating them with the child's everyday activities in the classroom and the home.

In summary, collaboration amongst professionals (especially teachers, SLTs and educational psychologists) and between professionals and parents is widely accepted as a desirable goal. However, the crucial question of how such collaboration may be achieved most effectively is, to date, largely unanswered. This is the central focus of the research reported in this document.

Aims of the research

The aims of the research were:

1. To identify the speech & language therapy needs of pupils with special educational needs, by examining the extent and nature of involvement of SLTs with children and young people in the educational context in the current twelve regional and island authorities of Scotland.

2. To examine the extent and nature of collaboration amongst parents and professionals, and the forms of assessment and service delivery to children and young people with speech, language and communication difficulties.

3. To assess the effectiveness of different models of service delivery and collaboration in relation to teachers', parents' and SLTs' perceptions and expectations.

In the pursuit of these aims, both quantitative and qualitative methodologies were used (see Chapter 2), involving close collaboration between the research team and parents, care givers and professionals. Previous studies examining the service provision for children and young people requiring speech & language therapy have been carried out in collaboration with the professional body (the Royal College of Speech & Language Therapists) and the National Paramedical Advisory Committee. However, in our view, this study represents the first attempt to address systematically the question of service delivery taking account of the needs, perceptions and expectations of the different groups of people involved: parents, teachers, SLTs and other professionals.

Several groups of people (parents, SLTs, teachers and others in the education profession) share a common concern and interest in the optimal delivery of high quality speech & language therapy services to children and young people with speech, language and communication problems. We have therefore aimed to make this report accessible to readers with differing perspectives by including background material which may be very familiar to some groups but not to others; some readers may find that they can skip some of the sections in Chapter 1. Since the focus of the research is on the role of SLTs, we have included more detailed introductory information about that professional group.

Structure of the report

In addition to this brief introduction there are seven chapters.

CHAPTER 1 expands upon this Introduction to provide a more detailed account of the background of the research together with a critical account of recent, significant developments in the provision and organisation of speech & language therapy; the changed thinking about special educational needs and the related legislation; the centrality of parents as partners with professional groups; and how the school curriculum affects pupils with special educational needs. It examines in detail the scale of speech & language therapy needs and presents an account of the professional framework within which SLTs operate. This chapter also considers the processes of identification and assessment of those individuals in need of speech & language therapy.

CHAPTER 2 describes in detail the methodology adopted in the research.

CHAPTER 3 presents data, largely quantitative, drawn mainly from questionnaires, on speech & language therapy provision.

CHAPTER 4 describes two case studies which highlight characteristics of innovative collaboration in mainstream primary schools, and identifies enabling factors.

CHAPTER 5 identifies key policy issues arising from the research; proposes possible guidelines for effective speech & language therapy services in educational settings; and examines the utility of a model where the focus is on *educational need* rather than on *medical disorder*.

CHAPTER 6 draws largely on qualitative data to provide a detailed and critical examination of examples of effective, collaborative practice. The focus is on different forms of organisation and patterns of provision, with a view to identifying what it is that SLTs can achieve in different settings through effective service delivery and collaborative working with educational staff.

CHAPTER 7 concludes the report by summarising the major implications of the findings for policy and professional practice.

In addition, copies of the questionnaires, details of how they were distributed and more detailed analyses of questionnaire data are provided in the appendices.

CHAPTER 1

Background and Recent Developments

Introduction

Readers of this report are likely to come from a variety of professional backgrounds and may have different knowledge bases, terminologies, and perspectives. Speech & language therapists (SLTs), teachers and parents all have different ideas and expectations about which children need speech & language therapy, how SLTs work, and what therapy can achieve. The aim of this chapter is to present historical and factual material on changing views, legislation and practice in the areas of speech & language therapy and the education of pupils with special educational needs. This should facilitate a sharing of perspectives and provide an essential backdrop against which to interpret the findings of this project.

Speech and language therapy

Speech & language therapists: roles and qualifications

SLTs aim to help people who are experiencing difficulties with one or more aspects of communication or with eating and drinking. They work in a variety of locations with a wide range of client groups of all ages, and with many different disorders. In 1991 'speech therapists' changed their name to 'speech & language therapists' in order to represent more accurately the broad role which has emerged since the founding of the profession during the early years of this century. The overwhelming majority of SLTs are women; in Scotland, less than 1% of SLTs in employment are men.

Although SLTs are commonly based in a health service setting, they work in a wide variety of locations. As well as working in hospitals, health centres and clinics, they also work in schools, nurseries and other educational premises; day centres and other social work locations; and clients' own homes. Pupils with speech & language therapy needs are educated in a variety of settings, with differing levels of additional support: mainstream classrooms, special classes/units/schools, residential schools, in both the state and voluntary sectors.

SLTs work with people of all ages, both children and adults. The profession prides itself on providing a 'cradle to grave' service: from the newly born child with a cleft palate and a need for help with feeding, to the needs of an elderly person whose ability to communicate has been devastated by a stroke. SLTs work with people whose communication disorder may be associated with physical disability, learning difficulties, sensory impairments, and multiple complex disabilities (including cerebral palsy, Downs syndrome, autism, traumatic brain injury), as well as those with more specific speech, language and communication delays and disorders.

All those who wish to practise as SLTs must satisfactorily complete a course accredited by the Royal College of Speech & Language Therapists (RCSLT), which is the professional body governing the speech & language therapy profession in the UK. The RCSLT maintains a register of members of the profession. The award of a certificate to practise is conditional upon a pass in the clinical/practical component as well as the academic component of an accredited course. The core disciplines studied are child development, speech & language pathology, linguistics and phonetics, anatomy and physiology, audiology, psychology and research methodology.

In Scotland, both ordinary (three-year) and honours (four-year) undergraduate degree courses leading to a speech & language therapy qualification are offered at Queen Margaret College, Edinburgh and the University of Strathclyde. The combined output from these institutions is around 55 SLTs per year. In Scotland, it is possible for those with a relevant first degree to follow an accelerated route to the (undergraduate) degree. In recent years, a significant number of graduates with degrees in related subjects (such as linguistics or psychology) have undertaken the two-year postgraduate courses now available elsewhere in the UK, and these entrants to the profession represent an increase in the numbers overall. Since the RCSLT's certificate to practise is equally valid across the UK (and indeed in Ireland and certain other English-speaking countries), a number of Scottish-qualified SLTs are lost to other parts of the UK each year. Of course, Scotland in turn benefits from being able to employ SLTs from the rest of the UK.

How are speech & language therapy services organised?

The overwhelming majority of working SLTs are employed within the National Health Service. A few are employed directly by charitable institutions and voluntary bodies; in Scotland the largest non-NHS employer is the Scottish Council for Spastics (soon to be Capability). Very few SLTs, particularly in Scotland, work entirely in private practice.

Speech & language therapy is an 'autonomous' profession within the National Health Service; individual SLTs are solely responsible for diagnosis, treatment and discharge of their clients. The current organisation of speech & language therapy services is based largely on the recommendations of the 1972 Report of the Committee of Enquiry into the Speech Therapy Services, the 'Quirk Report'. This report covered a range of issues affecting the speech therapy service (as it was then called), issues such as staff recruitment, service structure, education, research and developments in the role of the profession.

An integrated service under a unified and extended NHS management structure was put into effect throughout Scotland from 1974, and the employment of SLTs within the NHS is governed by the National Health Service (Speech Therapists) Regulations 1974, as amended by Statutory Instrument no. 208 (S20/85) National Health Service (Scotland). Whereas speech therapists before this time were employed by Education Departments, Health Boards and other agencies, all speech therapists working in the public sector were henceforth to be employed by Health Boards, irrespective of the client group with whom they worked.

There seems little doubt that many benefits to the speech therapy service resulted from Quirk. In 1988, a working group of the Sub-Committee for Speech Therapy of the National Paramedical Consultative Committee wrote, "A fragmented service, with practitioners at different levels of qualification often working largely in professional isolation, has given way to a well planned and expanded service with strong professional leadership, providing a wider variety of more sophisticated services and continuing its commitment to its traditional client groups." (SHHD, 1988)

Some of the new speech therapy departments which resulted covered all the services within an area health board; others were organised within the district divisions of the board. With a few exceptions, speech therapy departments were providing a comprehensive and integrated service to all client groups, and speech therapists continued to work in educational and social work locations as well as in NHS locations.

As a result of the health service reorganisations which have taken place in recent years, most SLTs are now employed by NHS Trusts, apart from a few who are employed by the island health boards. Speech & language therapy departments are now less likely to have a remit covering *all* client and service groups and service locations. For example, community speech & language therapy services for children are less likely to be integrated with the acute hospital sector, especially in the more urban areas. Some aspects of the fragmentation taking place are worrying; smaller teams focused exclusively on a paediatric caseload may lose the benefit of knowledge from other client groups thus de-skilling the service to children. However, there may be positive implications for speech & language therapy services to schools. Small paediatric teams may have fewer conflicting priorities and offer possibilities for a more tightly co-ordinated service.

How do people gain access to speech & language therapy?

SLTs maintain an 'open referral' system (CSLT, 1991: p. 20) – that is, a member of the public has direct access to the service, and can request an appointment with a SLT without going through another agency, such as a general practitioner. In practice, however, very few self-referrals occur. Of the pre-school children referred for speech & language therapy, most are referred by their health visitor. Smaller numbers are referred by other NHS staff, by social work nurseries/children's centres, by teachers in nursery schools or by educational psychologists. Most school-aged children with speech, language or communication problems will have been referred to a speech & language therapy service before school entry; a child who is referred for the first time during the school years is likely to be seen as a 'late referral'. The hypothesis has been that such a child will be at a disadvantage in terms of their potential for catching up and will be more likely to be at risk of developing secondary difficulties, such as problems with aspects of literacy or numeracy, socialisation problems or emotional/behavioural problems. One of the main planks of service development in recent years has been to identify and treat problems as early as possible, and in services to children, this has led to an emphasis on improving detection and intervention within the pre-school years.

Assessing speech & language therapy needs

Differing perspectives

Examples of differing perspectives

A teacher might find a pupil to be quiet and 'no trouble', but of low general abilities, and wonder why he was singled out for therapy when his speech was quite clear. The SLT might perceive the same pupil as being of at least average abilities, but under-achieving in certain curricular areas because of specific problems with comprehension of language.

A teacher might consider a pupil in urgent need of speech & language therapy because his speech is unintelligible. The SLT might not treat him because his underlying language is normal, and although speech is poor, it is more immature than deviant and she considers it likely to improve with maturation.

Parents might be told that their child has been referred to and is receiving help from the SLT, but might then be puzzled as to why their child never seems to 'go for speech & language therapy', although the SLT is regularly in and around their child's classroom.

One of the aims of this project was to assess the speech & language therapy needs of pupils with special educational needs. Mismatches sometimes occur between the views of different groups regarding the nature and extent of speech & language therapy needs. For example, interviews revealed that different professionals did not always understand each others' criteria of speech & language therapy 'need', nor each others' priorities. Our survey of parents suggested that a number of aspects of the delivery of speech & language therapy puzzled them, for example, the type of therapy provided, or the timing of decisions to cease therapy did not always meet their expectations. Our surveys of teachers and of SLTs revealed that there were perceived to be pupils whose needs were as great as those receiving therapy, but who were not receiving therapy. Our research suggests that these mismatches may be quite common. They are, however, not generally explicit, may not always come to light and, even if they do, they are not always easily explained.

Not surprisingly, the literature which has attempted to define, analyse and estimate speech & language therapy needs has been written primarily from the perspective of the speech & language therapy profession. Such literature will be reviewed in this chapter in order to provide a starting point for interpreting our findings and in order to highlight some of the complexities involved in assessing speech & language therapy needs.

The scale of speech & language therapy needs

Naturally enough, educationalists concerned with speech & language therapy issues generally look only at the school population. They may be unaware of the overall size and scope of speech & language therapy services. Services to education cannot, however, be considered without some reference to the wider context of speech & language therapy.

In 1972, the Quirk Report estimated that 324,180 people in the UK were 'needing help' from speech therapy services (Committee of Enquiry into the Speech Therapy Services, 1972: p. 80) and recommended a ratio of 6 speech therapists per 100,000 population. Enderby and Phillips (1986) attempted to estimate the number of people in the UK with speech and language disorders associated with a range of developmental and medical conditions, and arrived at a figure of 2.3 million people overall, although no attempt was made to estimate how many of these people required speech therapy services. A subsequent study reviewed available epidemiological data on the size of the speech and language-impaired population in the UK, and then attempted to estimate the number of SLTs and the amount of therapy time required to service the needs of this population (Enderby & Davies, 1989).These two studies have been criticised (Bryan, Maxim, McIntosh, McClelland, Wirz et al., 1991) for excluding people with a number of conditions such as autism and stammering, with whom SLTs are involved and who are recognised as client groups in 'Communicating Quality' (CSLT, 1991)[1]. Nonetheless, the Enderby and Davies' estimate, that 26.2 speech therapists were required per 100,000 population, was considerably greater than the 6 per 100,000 suggested by the Quirk Committee. Enderby and Davies attribute the difference partly to different epidemiological bases for the studies and partly to the 'changing nature and range of speech therapy over the last two decades' (CSLT, *op. cit.* p. 327). They point in particular to the expansion in provision for people with learning disability (learning difficulties), those with progressive neurological conditions and the elderly, client groups which received minimal attention in the Quirk Report.

In 1988, the Sub-Committee for Speech Therapy of the National Paramedical Consultative Committee (NPCC) reported that Scotland as a whole had achieved the Quirk ratio, but that the global figure concealed wide differentials between health boards and between different sectors of the service (SHHD, 1988: p.20). In 1990 the Manpower Planning Advisory Group reported 5.9 full-time equivalent speech therapists per 100,000 population across the UK – below Quirk recommendations. (Taking those two findings together indicates that Scotland was better provided for than other parts of the UK.)

In 1990 there were 7.3 full-time equivalent SLTs per 100,000 population (SOHHD, 1993). As we will see in Chapter 3, our current research shows that in Scotland (as at March 1994) there are 13 SLTs per 100,000 population – 100% greater than Quirk recommendations but 50% below Enderby and Davies' standards.

Statistics, published annually by the Information & Statistics Division of the Scottish Office (ISD), show that out of Scotland's population of 5,132,400, over 68,651 people were seen by SLTs in 1993–4. This represents a 10% increase over the previous year, and is over 83% more than the number recorded for 1982–3. The fact that more people are seen by SLTs each year (and that there are more SLTs than before, as we shall see in Chapter 3) does not, however, necessarily mean that there are 'enough' SLTs and/or that all the speech & language therapy needs are being met. There appears to be a pattern of ever-increasing need (or at least 'demand') for speech & language therapy which continuously outstrips increases in provision.

---

[1] See Appendix 4 for a complete list of recognised client groups.

Rising demands on speech & language therapy services

Determining 'need' is not as straightforward as it might seem. Needs are not 'absolute' and do not reside entirely within the individual client. And service needs do not equate exactly with 'demands' upon a service. There is evidence to show that demands on speech & language therapy services have been rising steadily over the past 20 years, both quantitatively and qualitatively. The NPCC working party (SHHD, *op cit.*) reviewed patterns of need and demand for speech & language therapy services, and reported an increase in the demand for speech & language therapy in response to a variety of external factors:

- Increased recognition of the importance of the role of communication in enhancing quality of life in individuals with disabilities
- Increasing awareness of the potential for improvement in communication skills
- Development of new therapeutic techniques
- Changes in incidence of certain conditions, for example, better survival rates of children with severe multiple disabilities
- Wider definition of 'special educational needs'
- Better identification of children with special educational needs
- Technological innovations enabling provision to new client groups (for example, adults with eating/swallowing difficulties)
- Greater readiness to refer people for speech & language therapy

Context is also relevant. Speech, language and communication difficulties might in the past have been 'taken for granted' in people in special schools and long stay institutions, but their impact (and therefore the need for therapy) may be perceived as much greater on the lives of individuals in mainstream schools and living in the community. Society's perception of needs and the right of an individual to help, from statutory sources, has also altered over recent decades. The physical location of clients of speech & language therapy services has been changing in recent years and has created new patterns of demand. As a result of educational policies of integration, instead of being clustered together within special educational facilities, speech & language therapy clients may now be scattered widely across large areas, necessitating expensive and time-consuming travel on the part of SLTs and other support staff. The amount of *other* support available to clients, in the area of communication, also affects the demand on speech & language therapy services, although not necessarily in a straightforward way.

In addition to the growth in demand for speech & language therapy services from new and existing client groups, assessment and treatment methods have become more sophisticated, calling for higher levels of knowledge and a wider range of skills, as new clinical areas have opened up. Many of these developments are closely linked to technological advances such as computers, augmentative and alternative communication aids, video and videofluoroscopy.

The changing role of speech & language therapists

Changes in the way the speech & language therapy profession plans, organises and delivers services are imperative due to ever increasing needs and demands, combined with seemingly continuous 'reforms' (changes) of NHS, Social Services and Education structures and services, a climate of financial restrictions, and recruitment difficulties in the speech & language therapy profession. And in fact there have been enormous changes in the speech & language therapy profession within the last decade. However the perceptions of other professionals, parents, and the general public at large of the nature of speech & language therapy needs and services may be slower to change, and may continue to relate to an older model of service delivery. This may account for some of the confusion over the 'role of the speech & language therapist'.

Clarification of the role of the SLT may affect many groups, not just SLTs and their clients. For example, making clearer that SLTs cannot be solely responsible for all communication needs, may help others (families and professionals) to perceive what their own role may be in relation to these communication needs. It is in the interests of SLTs themselves as well as of their communication impaired clients to make their work more transparent to others outside the profession, and to work towards a more collaborative model for meeting communication needs. 'Communicating Quality', a recent publication by the Royal College of Speech & Language Therapists has taken a first step in this direction (CSLT, 1991).

Speech & language therapy: a professional framework

The following section is based in the main upon 'Communicating Quality' (College of Speech & Language Therapists, 1991)(CSLT, 1991)[2]. That document is intended to fulfil a dual role.

> "Firstly, as a guide to good practice as perceived by the majority of speech and language therapists in the UK. Secondly, as an encouragement to those responsible for both providing and commissioning services, to work to achieve the quality standards described."
>
> (Foreword)

'Communicating Quality' is a document which, for the speech & language therapy profession, explicitly and systematically lays out "unequivocal statements on practice and professional standards". Although its intended focus is different, in a sense it is the speech & language therapy profession's equivalent of the 5–14 Curriculum Guidelines; for the first time, it establishes, at a UK national level, a framework and a common vocabulary which make the work of the profession much more accessible than ever before and which facilitates open discussion with other professionals, including teachers.

'Communicating Quality' is highly relevant to the current project, as it provides a point of reference in relation to which the role of SLTs working in Scotland with pupils with special educational needs may be considered. It is recognised that speech & language therapy services may always have to struggle with competing priorities, in the context of finite resources, but it is expected that all SLTs are aware of these professional guidelines and are working towards achieving the quality standards described.

'Communicating Quality' defines the role of all SLTs as being to "discharge a duty of care through assessment, and diagnosis of communication disorders, their consequent treatment, and any decision as to the continuance of treatment" (p. 198). Guidelines for programmes of care (pp. 21–22) include (amongst many others) the following, which are of particular relevance to the context of special educational needs:

- The identifying and agreeing of achievable goals between the SLT and client/carer, including expected outcomes and timescales.
- Ongoing evaluation of the effectiveness of the programme by both SLT and client/carer, with modifications as necessary.

---

[2] 'Communicating Quality' is currently being revised and will be re-published by the end of 1996.

- "Throughout the period of contact the speech & language therapist will ensure that any other professionals or agencies involved with the client/carer will be kept informed of progress, as appropriate. Specific advice and training by the speech & language therapist of other professionals in regular contact with the client may be necessary."
- "The speech & language therapy treatment may form part of a multi-disciplinary programme of care and may include joint aims and intervention."

It is therefore explicitly considered good professional practice for the SLT to expect and encourage the active involvement of parents and of other professionals, in a programme of speech & language therapy care. The implication is that clients' speech & language therapy needs cannot be well met by SLTs working in isolation.

'Communicating Quality' details all client and service groups, with guidelines to appropriate models of care, and to good practice with each, and lists presenting disorders. (See Appendix 3 for details.) The current study focuses exclusively on children and young persons. In terms of presenting disorder, a large proportion of the pupils in Scottish schools requiring and receiving speech & language therapy will fall into the category of 'developmental speech & language disorders.' We have therefore included in this report, in Appendix 4, the full definition of the client group having developmental speech and language disorders; the aims and principles of service delivery; and guidelines to assessment and to intervention with this group. Repeatedly, in these guidelines, there is reference to including the observations and assessment findings of parents and of other professionals; joint planning, with education staff, of therapy programmes; working in conjunction with parents and other professionals; working through parents/carers/nursery staff/education staff. It is emphasised that "intervention is the joint responsibility of therapist, child, parent/carer and/or other professionals" (p. 160).

Working with and through others, however, presupposes a shared perception of need, an understanding of the aims and principles of intervention, a general agreement to cooperate and collaborate, a shared knowledge of how to participate in the therapy process, and the existence of resources – time, especially – to enable participation. As we will see in later chapters, our research indicates that these conditions do not always apply.

It is clear that a further aspect of 'need' in speech & language therapy is that of provision of training to other professionals. 'Communicating Quality' explicitly states: "Intervention should include the provision of in-service training to other professionals involved with the child on both a formal and informal basis" (p. 161). This view of training needs is essentially client/disorder centred, which may differ somewhat from the view of educationalists, who may see teachers' need for education in speech, language and communication as a much more general and ongoing need.

Identifying individual needs and planning intervention

As well as paying attention to the findings of others, SLTs of course use their own assessment instruments (standardised and unstandardised) and professional judgement, in the assessment and diagnosis of children and in the planning and carrying out of intervention. There is no single kind of 'speech & language therapy'. SLTs may decide to offer direct and/or indirect therapy; ongoing therapy or blocks of therapy; regular or intensive therapy; individual, paired or group therapy. They may consider the use of assistants and/or volunteers. Models of speech & language therapy have evolved in recent years. The traditional model of speech & language therapy was directive, 'norm-referenced', and tended to focus upon the child's 'performance', often in artificial 'test-like' situations. Contemporary models of therapy are more child-centred, more facilitative than directive, and more functional, that is, they take into consideration the learning environment of the child. This type of therapy, being more naturalistic and more tightly integrated with the child's environment may be harder for parents and teachers to 'identify' as speech & language therapy, if they have as their frame of reference the 'medical model', according to which more treatment eventually 'cures' you.

SLTs use a wide variety of methods, materials and technologies. Their decisions and choices on these are seldom made purely on a clinical basis, rather they are likely to reflect a mixture of clinical and practical considerations, depending on the context of each child. The practical considerations may include the nature of the educational environment of the child, and the support on hand in that location to carry through a speech, language and communication programme. Following assessment of a child and the child's environment, a SLT is likely to target one or more of the following skill areas as part of a programme of direct and indirect therapy:

- Understanding of spoken language (word and sentence meaning; non-literal meanings)
- Expressive language (grammatical constructions; word-endings; expressive vocabulary)
- Appropriate use of (and prevention of misuse of) the vocal apparatus (breathing; posture; relaxation; nasal/oral airflow; tone; pitch)
- Phonology and articulation ('pronunciation'; using all the sounds of English at the beginning, in the middle and at the ends of words; getting syllables in the right order; the ability to detect and manipulate rhyme and sounds-in-words, i.e. 'phonological awareness')

Less familiar to teachers and parents, perhaps, are the following areas which may also be targeted:

- Attention control and listening skills
- The social functions of language and communication
- Understanding and use of the rules of interaction and conversation, such as how to take turns, start and finish conversations or match levels of politeness with the social status of the person being addressed
- Intonation patterns, stress and rhythm in utterances – used to indicate the difference between a statement and a question ("You're sick!" versus "You're sick?"), as well as conveying information about, for example, the speaker's attitudes
- Understanding and use of non-verbal communication, such as facial expression, eye gaze or 'body language'

Intervention often targets skill areas that are fundamental to speech, language and communication:

- Use of different senses (auditory, visual, kinaesthetic and tactile perception)
- Control of body movement (gross and fine motor skills, including co-ordination of movements of the lips, tongue and other vocal musculature)
- Play and social skills

Non-oral communication also falls within the remit of the SLT:

- Introduction and use of an augmentative or alternative communication system, such as manual signing, symbol chart, or high technology speech output aid, and training of others in its use
- The effects of underlying problems of speech & language upon comprehension of written language, and upon written expression and spelling

Direct therapy programmes always include some aspects of 'indirect therapy'. For example, attention will be paid to the communicative environment of the child. Rather than attempting to modify the child's communication more directly, intervention may focus on modifying the communicative environment, for example, by training parents, carers or teachers to provide more opportunities, or more appropriate opportunities, for communication in the child's everyday life, or to monitor and modify their own language in line with the child's comprehension levels.

In addition to direct and indirect therapy, there are a number of 'non-client contact' activities that are considered to be very important components of the SLT's role. These would include liaison with parents, other professionals and support staff; planning, preparation and writing of programmes and materials both jointly with others and by the SLT for use by others; attendance at case conferences and other meetings about clients; and the presentation of training sessions for parents and other professionals, for example, in the use of Makaton signing[3]. It would also include keeping client records and writing reports. 'Communicating Quality' also highlights, in the 'Core Guidelines and Professional Standards', the need for time and resources for professional staff development to ensure that SLTs "maintain and develop appropriate clinical standards for each care group" (p. 23).

Special educational needs

Changing views and legislation

The educational background to the current project has its roots in a series of documents and legislation which have appeared over the past twenty years. In Scotland, an influential HM Inspectorate report entitled, 'The Education of Pupils with Learning Difficulties in Primary and Secondary Schools in Scotland,' was published in 1978 (SED, 1978). This report focused particularly upon pupils in mainstream schools and represented a new conceptualisation of ways of meeting the needs of pupils with learning difficulties. The report was critical of the then existing model of remedial education and advocated a departure from the practice of extracting pupils with difficulties from the classroom. In essence the report moved away from seeing problems as arising uniquely from 'within the pupil' and located problems as being within the school curriculum and within teaching practices.

In the UK as a whole, the Warnock Report (Committee of Enquiry into the Education of Handicapped Children and Young People, 1978) advocated a new view of 'handicap' as an educational condition, rather than as a medical condition. The concept of a *continuum of need* was established[4], with support and special educational provision determined on the basis of each individual's educational needs, rather than upon definitions of discrete 'categories' of handicap. The Warnock report also stressed the importance of collaboration between education, health and social services.

Another major theme of the Warnock report was the emphasis upon the right of all pupils to benefit from a broad, balanced, relevant and differentiated curriculum. Warnock estimated that 20% of the school population might experience learning difficulties at some point in their education, and require additional support. It was recommended that as many as possible of those pupils with special educational needs (at least 18%) should be integrated and supported in mainstream schools rather than segregated into special education.

Important aspects of both the Warnock Report and the HMI Report were enshrined in the Education (Scotland) Act 1980, amended by the Education (Scotland) Act 1981. The idea of the individual profile of the special educational needs of a pupil was formalised as the Record of Needs, which was to be drawn up by education authorities in partnership with parents and in consultation with health and social work professionals.

---

[3] Makaton is a system of manual signs used for communication.

[4] It has been pointed out since then that this linear continuum of need encouraged conceptualisation of provision in terms of *quantity* only, whereas ideally both quantity and *quality* should be considered (Strathclyde Regional Council, 1994: p. 1, quoted by Thomson et al 1995: p. 47).

For the purposes of the 1981 Act, a child is considered to have special educational needs "if he has a learning difficulty which calls for special educational provision to be made for him" (§1:2). Although this is a somewhat circular definition of special educational needs, the resulting emphasis on provision helps to focus upon the whole educational context of learning rather than on pupil deficits.

Records of needs

Across Scotland, there is great variability in recording policies and practices (Thomson, Stewart & Ward, 1995). Many children with speech & language therapy needs have Records of Needs, but the present report shows that large numbers of children with speech, language and communication therapy needs are *not* recorded (see Chapter 3). Such variation may result where, in the view of parents and professionals, adequate arrangements have been made for special educational provision, including speech & language therapy, without recourse to the opening of a Record of Needs. However, opening a Record of Needs has come to be seen by some parents and professionals as a means of ensuring access to necessary additional resources, including speech & language therapy services.

The Draft Circular 'Children and Young Persons with Special Educational Needs: Assessment and Recording Services' has launched a review of implementation of the 1981 Act in Scotland (SED, 1973). Responses to the Draft Circular (unpublished discussion paper, Children in Scotland, 1994) indicated that parents in particular felt that its directions were less specific and forceful than those of the corresponding document in England and Wales which predated it. Specifically, with regard to children's speech & language therapy needs, parents felt that the language of para. 236 "SOED and SOHHD hope that education authorities and health boards will cooperate closely" was not directive enough, and that health boards and education authorities should have a statutory obligation to work together in planning and providing for pupils with special educational needs.

Some parents and professionals view Records of Needs as potentially beneficial, in terms of enhancing the rights of individual children/pupils and facilitating individualised assessment of needs. Education officers, educational psychologists and doctors consulted in the course of a recent study which considered the criteria for opening a Record of Needs (Thomson, Stewart & Ward, 1995) expressed a number of serious concerns, including the lack of adequate resources; the time-consuming bureaucracy surrounding the process of recording; and the fact that the recording process sometimes provokes confrontation, rather than partnership, with parents.

Partnership with parents

One of the intentions of the 1981 Education Act was to allow for more involvement and consultation of parents, especially of pupils with special educational needs. Since then there has been a growing recognition of the importance of parental participation, and this is embodied in a series of other documents and statutory instruments. For example, The Disabled Persons Act (1986) addressed the need for continuity of support for pupils with Records of Needs leaving school; The Parents' Charter said that a child with special educational needs had "a right to an education ... which meets his or her requirements," (SOED, 1991: p. 10).

A recent HM Inspectorate report 'Effective Provision for Special Educational Needs' is unambiguous on the parental role: "The rights and responsibilities of parents are respected and they are actively encouraged to be involved in making decisions about the approaches taken to meet their children's special educational needs" (SOED, 1995:

p.9). In particular, speech & language therapy (or its lack) has been a focus of parental concern, often articulated through voluntary bodies such as the Association for all Speech Impaired Children (AFASIC), Invalid Children's Aid Nationwide (I CAN), the Scottish Down's Syndrome Association (SDSA), and culminating in some cases in use of formal procedures such as the Education (Appeal Committee Procedures) (Scotland) Regulations, 1982 (SI 1736).

Responsibility for provision of speech and language therapy

A legal test case in England (R. v. Lancashire County Council. Ex parte CM. 1989) established that in certain cases the need for speech & language therapy can qualify as a special educational need. The local education authority has a legal obligation to ensure that speech therapy is provided, even if that means that they have to purchase speech & language therapy services directly. While the Lancashire judgement strictly speaking related only to the English statute, the Scottish Office conceded that its substance was equally relevant to Scotland (SOED, 1992). The judgement strengthened the case of parents in their attempts to influence Scottish Office policy.

The legislation is clear that education authorities have a duty to make provision for all children and young persons with special educational needs, and to do so in accordance with the terms of a Record of Needs for those pupils for whom a Record has been drawn up. However, some education authorities experienced difficulty in securing from the health sector adequate speech & language therapy services and were thus in danger of failing to fulfil their statutory obligations. There were apparently not enough SLTs, or SLTs were 'spread thinly' across very wide caseloads which included adults and children (with and without Records of Needs). There were no mechanisms whereby education authorities, with a statutory responsibility to meet pupils' special educational needs, could determine or monitor how priorities for speech & language therapy treatment were set, what therapy was provided, and to which children it was provided. Education authorities, teachers and parents were less than satisfied. Against this backdrop, a need was perceived for changes in the delivery of speech & language therapy services to children and young people.

New arrangements for speech and language therapy services in education

In 1991, the Secretary of State for Scotland notified Directors of Education and Managers of Health Boards and Trusts of changes to the way in which speech & language therapy services were to be delivered to pre-school and school-aged children with Records of Needs. The primary intention of this initiative was to enable education authorities to have direct control over the financial resources required to discharge their statutory duties towards children with Records of Needs.

A document clarifying the Education (Scotland) Act 1980 and circulated to all Directors of Education in Scotland stated clearly that where speech & language therapy is a special educational need of children and young persons with Records of Needs, education authorities have a statutory duty to arrange suitable provision to meet that need is delivered to the child or young person (SOED, 1992). This document outlined new procedures for funding and delivering speech & language therapy services to pupils with Records of Needs. Directors of Education in Scotland were directed to purchase the necessary speech & language therapy services through contracts with NHS trusts and health boards.

> "Under these arrangements, education authorities will enter into specific contracts with health boards under which health boards will provide, for financial consideration, the speech therapy services which will enable the education authorities to discharge their statutory responsibility, under section 62 (3) of the 1980 Act, to secure provision of such services for recorded children. The contracts

will specify the level of provision required and the payments which education authorities will make."

An additional £2 million from central government resources was added to local authority resources for 1992–93 to assist education authorities in Scotland to meet the cost of such contracts. It was envisaged that the £2 million additional funding would cover at least the 1991–92 level of speech & language therapy provision to children with Records of Needs, on the basis of an estimation of costs carried out in discussions between the Scottish Office Education Department, the Association of Directors of Education (ADES), and the Convention of Scottish Local Authorities (COSLA). On this occasion, a corresponding amount was not transferred out of the health budget, so that the funding previously available in the health sector for speech & language therapy remained as before. Since speech & language therapy for pupils with Records of Needs was now to be financed from education budgets, it was anticipated that enhanced speech & language therapy resources would be available for those not covered by education-funded contracts.

The new money was allocated in the context of a two or three year transitional period. In 1994, COSLA was consulted as to whether there were further funding needs for the purchase of speech & language therapy services for pupils with Records of Needs. As a result of this consultation, a further £1 million was allocated to education authorities for purchase of speech & language therapy services. However, this was not new money but was 'top-sliced' from the health budget. The total of £3 million funding was allocated to regional councils but was not 'ring-fenced' for the purchase of speech & language therapy services. Future negotiations to determine the level of finance required for provision of speech & language service were to take place within the annual round of discussion between COSLA and the Scottish Office about the financial requirements of local authorities.

The new arrangements were intended to come into force on 1 April 1992 but in practice it took much longer—in some authorities years longer—for the necessary calculations, negotiations, mechanisms and contracts to be finalised.

The Secretary of State's (1991) Initiative brought major changes in the organisation of speech & language therapy provision for pupils with special educational needs. The precise nature of these changes and the rate at which they have occurred have varied considerably from area to area. Furthermore, these changes have been superimposed upon a legacy of previous changes in the organisation of speech & language therapy services, which were also implemented to varying extents across different areas. In order to assess the impact of the Initiative, it is crucial to be aware of the context in which it was introduced.

Prior to 1974, speech therapists who worked with children and young people were employed directly by education authorities and spent most of their time in schools, child guidance clinics or other educational premises. From 1974 (as a result of the Quirk Report), speech therapy services were re-organised and all speech therapists in the public sector were employed within the National Health Service. With this unification of the profession, paediatric speech therapists began to be accommodated in health centres, clinics and other NHS premises. During this period, early intervention for children with speech, language and communication difficulties was being promoted and the profession began to target pre-school children more vigorously. Close relationships were built up, in particular with health visitors, who became the major source of early referrals to speech & language therapy services. Many SLTs also discovered the advantages of the clinic setting for collaboration with parents and this reinforced the move towards a clinic-based service. The move to clinic-based work was not complete or uniform, however, and SLTs continued to work regularly in primary schools, especially in sparsely populated areas of Scotland, and in special schools. By 1991, however, there had been a considerable decline in school-based delivery of speech & language therapy, overall.

As the findings from the current study will demonstrate, the Initiative has had profound effects (both positive and negative) upon speech & language therapy services. Parents generally welcomed the Initiative as a positive step forward, assuring and protecting enhanced levels of speech & language therapy provision for their children, as well as providing the support of formal documentation. The Secretary of State's Initiative was an explicit recognition that in the case of children with Records of Need, a need for speech & language therapy is a special *educational* need.

Special educational needs and the curriculum

The 1980s and 1990s have also seen major reforms of the educational curriculum in both England and Wales and in Scotland. Although the new National Curriculum (England & Wales) and the 5–14 Curriculum Guidelines (Scotland) are each intended to be 'a curriculum for all', the original format of both made only minimal reference to pupils with special educational needs—giving some weight to the argument of Tomlinson (1982) that pupils with special needs are marginalised by the mainstream education system. The 5–14 levels and attainment targets, and the steps in which they progress, were devised for normally developing children; pupils with special educational needs may require developmentally earlier starting points, and smaller steps, both within and between levels. This has posed problems for teachers of such pupils, who have found a need for extensive elaboration of the curriculum (McIlhenney, 1990; SED, 1989). Many pupils with complex special educational needs are now described as 'working towards' or 'working within' Level A of the curriculum (now redefined as having no bottom threshold). Parents may find it discouraging that in terms of the national assessment and testing guidelines, their child may spend their whole school career 'working within Level A'—with little impression of progress. Teachers, lecturers and other professionals with responsibilities for pupils with special educational needs in Scotland have collaborated on development projects exploring ways of using the framework of the 5–14 Curriculum to improve the planning and delivery of educational programmes (SOED, 1993: p. 3) and materials are now becoming available to help teachers implement the new curricular framework.

The 5–14 Curriculum, Assessment and Testing, and Reporting guidelines are being implemented in stages. A recent evaluation study (SOED, 1994) showed that Scottish teachers felt 5–14 had generated a sharp increase in their workload, and caused extreme pressure upon them due to the lack of time, materials, support and money for implementation. On balance, however, teachers gave cautious approval to the content of the 5–14 materials. For example, positive views included a perception by secondary school teachers of better continuity of education between primary and secondary schools. Primary teachers liked the fact that 5–14 gave them a framework within which to work. Head teachers felt 5–14 helped them with whole-school planning and with reviews of teaching. The assessment and curriculum guidelines help teachers of pupils with special needs to identify those parts of the curriculum which require adaptation.

The main benefit of 5–14 for teachers of pupils with special educational needs, including speech, language and communication difficulties, has perhaps lain in the fact that 5–14 systematically documents and establishes at a national level the sort of practices that were previously only recognised informally at individual classroom level, now giving school policies a coherent nation-wide focus.

This is also of benefit to SLTs. 5–14 provides a shared, common framework within which they can work with teachers. 5–14 makes explicit the fact that speech, language and communication are clearly part of the curriculum. This makes it difficult for either teachers or SLTs to 'compartmentalise', or to defend attitudes of 'professional territoriality', whereby speech, language and communication are seen as 'the job of the SLT'. 5–14 clearly establishes speech, language and communication in the classroom as the shared responsibility of both teachers and SLTs. As will be argued in Chapter 7, this shared role needs to be recognised in future 5–14 curriculum development.

Summary

This chapter has provided a broad context within which to consider the role of the speech & language therapist (SLT) in the education of pupils with special educational needs. In particular, it has highlighted the following points:

(1) SLTs work with a wide variety of client groups, so their role in the education of pupils with special educational needs has to be co-ordinated with their other responsibilities.

(2) Speech & language therapy needs are not 'absolute' and do not reside entirely within the individual client. Furthermore, speech & language therapy needs cannot be directly equated with demands on speech & language therapy services (which are influenced by various external/contextual factors).

(3) Demands on speech & language therapy services have been increasing steadily and consistently outstrip provision.

(4) There has been a move away from the traditional model of speech & language therapy, in which speech & language therapy needs were perceived in terms of 'within-individual' presenting disorder. Instead, it is increasingly being recognised that speech & language therapy needs are diverse, are not all directly focused on the individual child or young person and can best be met through collaboration with parents and with other professionals.

(5) SLTs, teachers and parents may have different frames of reference and priorities, which underlines the need for communication and education amongst these groups about the roles and responsibilities of each.

(6) In the past two decades, government reports and legislation have emphasised the importance of catering for individual children's special educational needs, and of doing so as far as possible within a mainstream setting and in partnership with parents.

(7) Education authorities in Scotland have a legal obligation to meet children's special educational needs. Such needs may include the provision of speech & language therapy.

(8) Since most SLTs are employed within the health service, a Record of Need which includes speech & language therapy will usually necessitate collaboration and negotiation between the health and education authorities.

(9) An Initiative from the Secretary of State for Scotland has provided the authority and funds for education authorities to purchase speech & language therapy services for pupils with Records of Needs from NHS Trusts (and health boards in the Western and Northern Isles).

(10) The 5–14 Curriculum Guidelines may provide a shared framework for collaboration between SLTs and teachers, although elaboration of this curricular framework is necessary to cater for pupils with special educational needs.

CHAPTER 2

Methodology

Introduction

The project was designed to collect a variety of data which would provide as clear a view as possible of the provision of speech & language therapy to children and young people in Scotland. The intention was to gather information from a range of people involved with these children and young people. Speech & language therapy managers, speech & language therapists, teachers, educational psychologists, advisers in special educational needs and parents participated in the research. Data were collected through postal questionnaires to each of these groups and through interviews carried out on visits to schools.

During the first phase of the research, postal questionnaires were designed for each group in order to gather the particular information they had available and their different perspectives. (Copies of the questionnaires may be found in Appendix 5.) It was intended that the study would ask questions that would involve participants in as little additional work as possible, thus avoiding low rates of return and/or the danger of inaccurate information. The questionnaires collected quantitative and qualitative data. Development of the postal questionnaires for the five professional groups took place in the period November 1993 – March 1994. These questionnaires were sent out to each group in March for completion as at 31 March 1994, except for teachers who were asked to respond with reference to the Spring Term, January to March 1994. Questionnaires to parents were developed in the period March – October 1994. They were available on request to parents from November 1994 with return dates staggered up to 10 April 1995. SLTs distributed questionnaires to a sample of parents on their caseloads between 27 February – 10 March 1995 with a return date of 10 April 1995.

In the second phase of the research, between November 1994 and March 1995, visits to schools were carried out. Semi-structured interviews were carried out in order to build on the data collected through the postal questionnaires. The sample of individuals who participated in the interviews was drawn independently of the sample for the questionnaires, although coincidentally some individuals participated in both phases of the study.

Some questions were asked in such a way that the information could be compared with official statistics (ISD Scottish Health Service Common Service Agency, 1995), and with data collected in 1990 by a working group of the National Paramedical Advisory Committee (SOHHD, 1993).

The following section describes the process of data collection and who participated in the study.

Data Collection

Postal questionnaires

Postal questionnaires were constructed to collect quantitative and qualitative data from the following groups:

- Speech & language therapy managers (Appendix 5.1)

- Speech & language therapists (Appendix 5.2)
- Advisers in special educational needs (Appendix 5.3)
- Educational psychologists (Appendix 5.4)
- Teachers, including learning support teachers and class teachers (Appendix 5.5)
- Parents (Appendix 5.6)

Summary data on the numbers of questionnaires distributed and returned are given in Table 2.1.

Table 2.1: Numbers of questionnaires returned by parents and professional groups

	Total returned	Return rate
Speech & language therapy managers	49*	98%
Speech & language therapists	381*	~77%
Advisers in special educational needs	17	60%
Educational psychologists	11	34%
Teachers in:		
stand-alone nursery schools (10% sample)	12	50%
mainstream primary schools (10% sample)	386	52%
mainstream secondary schools (20% sample)	44	49%
special schools/units/classes (all)	362	55%
Parents:		
distributed via SLTs	329	41%
requested by parents	191	42%
Total	*1,829*	

* Figures do not include those with no remit for under-18s.

Speech & language therapy managers

The postal questionnaire to speech & language therapy managers aimed to gather numerical data on numbers of SLTs, of speech & language therapy assistants and of children and young people receiving a service as at 31 March 1994. Numbers were requested of locations where therapy had been provided in 1993/94 and of locations where it was required but not provided. Qualitative data were also sought on policies for assessment and referral, contact with parents and voluntary organisations, and effects of the Secretary of State's (1991) Initiative.

In particular, the numerical data requested included:

Staffing	Numbers of full- and part-time SLTs and therapy assistants, numbers of whole-time equivalent (WTE) posts, vacancies, sources of funding, numbers of SLTs and assistants working with children/young people

Provision	Numbers of different types of locations (for example, primary schools, special educational facilities for pupils with physical disabilities) where speech & language therapy had been provided 'on-site' during 1993/94, and how many locations were without but required such provision.
Clients	Number of children/young people (0–18) who were within the manager's service, on the 31 March 1994: total number receiving therapy, on review, waiting for assessment, and waiting for therapy, and how many within each of these categories had Records of Needs

The questionnaire was sent to all speech & language therapy managers in Scotland, including those outside the NHS, e.g. Scottish Council for Spastics. Forty-three managers whose service significantly provided therapy to children/young people (0–18 years) returned completed forms; only one service area with a remit including children/young people is not covered by a completed questionnaire. The management post in this area was vacant at the time of data collection. Managers whose service was 'adult only' did not usually return a completed questionnaire, although some did return a form where there was occasionally a client aged under-18, such as in a hospital setting following a head injury.

Managers were also asked to nominate education locations which they would recommend as examples of *particular styles* or *models of service delivery*. These recommendations were used, in conjunction with nominations from advisers in special educational needs, to choose sites for the research team to visit subsequently for interviews.

Additional information on distribution and return rates for the questionnaire to speech & language therapy managers is given in Appendix 1.1.

Speech & language therapists

The postal questionnaire to SLTs gathered data on the type of SLT, how they organised their work, the type and size of their caseload, how they worked in different locations and who they collaborated with. SLTs were also asked about training they had been involved in and the contact they had with parents and voluntary organisations.

All SLTs working in Scotland on 31 March 1994 received a questionnaire. They were distributed through speech & language therapy managers but returned directly in postage paid envelopes.

428 SLTs returned completed forms. This constitutes a return rate of 65% of all SLTs working in Scotland on 31 March 1994 (ISD Scottish Health Service Common Service Agency, 1995). However, since many SLTs who did *not* work with children/young people did not return questionnaires, the true return rate from SLTs with a remit relevant to this project is higher than 65%. 381 of 428 SLTs participating in the research had children/young people on their caseload. They make up over three-quarters of SLTs noted by managers as working with this children and young people.

Additional information on distribution and return rates for the questionnaire to speech & language therapist is given in Appendix 1.2.

Advisers in special educational needs

Questionnaires to advisers asked about what teaching provision operated for children/young people with speech, language and communication problems in their area, what was happening in terms of special initiatives and in-service training, their relationship with the speech & language therapy service, and their contact with parents and voluntary organisations.

All advisers in Scotland were sent a questionnaire. Where there was no designated person in this role the questionnaire was sent to the principal educational psychologist in the authority. Seventeen (60%) of the 28 questionnaires distributed were returned.

Advisers were contacted again and asked to nominate education locations which they would recommend as examples of *interesting or innovative practice*. These recommendations were used, in conjunction with nominations from speech & language therapy managers, to choose sites for the research team to visit subsequently for interview studies.

Educational psychologists

Educational psychologists were asked about numbers of children/young people known to their service with speech, language and communication problems and what numbers of these children/young people had Records of Needs. This professional group was also asked about their recording policies and practices for this group of children/young people, their relationship with the speech & language therapy service, and their contact with parents and voluntary organisations.

All principal and divisional educational psychologists were sent forms; multiple forms were sent to regions divided into divisions/areas and a single questionnaire to the remainder. In total, 32 questionnaires were sent out. The return rate from this group was relatively low at 34%. In the main, this was reported to be because the figures were difficult or impossible to collect with current databases and/or time constraints.

Teachers

The teachers' questionnaire collected a variety of data about pupils in each teacher's class, how pupils received their therapy, the contact teachers had with SLTs, in-service training, and what teachers wanted in the future for these pupils and other pupils with speech, language and communication difficulties.

Teachers in different types of schools were surveyed. The research team collected data from:

- Teachers in special educational facilities
- Nursery teachers
- Mainstream primary teachers teaching different age groups
- Learning support teachers in primary schools
- Learning support teachers in secondary schools

Head teachers in all known (394) special educational facilities were sent questionnaires; 373 of these locations were known to the Scottish Office Education Department in December 1993 and information on an additional 21 was provided by education authorities. These included independent schools and all special units and classes, whether or not they were attached to mainstream schools. Each head teacher was sent three questionnaires. They were asked to give them to three class teachers whose classes represented a spread of ages and/or ability level (or to fewer teachers in schools where there were less than three members of staff). Three of these 394 locations returned the forms without completing them at all. Of the remaining 391, 216 (55%) returned one or more completed questionnaires; thus 362 teachers from special educational facilities participated in the survey.

It was not feasible to survey all nursery, primary and secondary schools in Scotland. A random sample of each type of education establishment was drawn for the research team by the Scottish Office Education Department. The random samples of primary and secondary schools were drawn with regard to statistics on free meal entitlement, to ensure a spread of schools in terms of the socio-economic characteristics of their intake.

The secondary school sample was also drawn with reference to size of school. The samples and returns were as follows:

- A 10% sample of stand-alone nurseries in each region

    24 nurseries were sent a questionnaire

    12 nursery teachers returned completed forms, a return rate of 50%

- A 10% sample of mainstream primary schools in each region, with regard to the proportion of pupils with free meal entitlement

    237 primary schools were sent sets of five questionnaires. Head teachers were asked to give them out to a learning support teacher and to teachers teaching different classes in the school: nursery, primary 1/2, primary 3/4/5, primary 6/7

    386 teachers in 124 primary schools returned completed forms, constituting 52% of the schools surveyed

- A 20% sample of mainstream secondary schools in each region, but not less than three schools per region, with regard to the size of school (small = up to 400 pupils, medium = up to 1,000 and large = 1,000 and over) and the proportion of pupils with free meal entitlement

    89 secondary schools were sent a questionnaire. Head teachers were asked to give them to a learning support teacher or a teacher with responsibility for learning support

    44 learning support teachers in these secondary schools returned completed forms, giving a return rate of 49%. (An additional 34 learning support teachers in secondary schools also returned forms which they had received through the distribution of questionnaires to secondary schools with special schools and units attached.)

Parents

Initially, researchers met with a group of 12 parents to discuss what issues they saw as important. These families had children of a range of ages and a variety of communication difficulties. The points raised by these parents informed the design and content of the parent questionnaire. Parents were asked to provide information about their child's difficulties, education, and speech & language therapy.

Questionnaires were distributed in two ways: parents could request questionnaires, and questionnaires were distributed by a sample of SLTs, as follows.

Parents were invited to call or write for a questionnaire. Notices to this effect were included in the publications of voluntary organisations and parents groups, such as Children in Scotland, the Scottish Down's Syndrome Association and local AFASIC (Association For All Speech Impaired Children) groups. Where a newsletter was not due to be published, several groups sent information leaflets to their members. Notices found their way into a number of different locations, including noticeboards in schools and GP surgeries. 459 parents' questionnaires were requested, mostly by individual parents, but some were requested by parents' groups, voluntary organisations and, in one instance, a school. 191 (42%) of these 459 questionnaires were returned.

808 questionnaires were handed out by a sample of 101 SLTs throughout Scotland, representing over one-quarter of those known to work with children and young people. Each of these 101 SLTs was asked to give a questionnaire to eight clients with whom they were involved during the period 27 February to 10 March 1995; involvement did not have to be face-to-face contact but could include writing reports or attending case-conferences. They were asked *not* to hand out questionnaires to people in very similar

circumstances, but to give them out in such a way as to reflect the variety of their own caseload. Pre-paid envelopes were enclosed for SLTs to post on forms to parents with whom they did not come into contact. All questionnaires included addressed, postage-paid return envelopes. 329 (41%) of these 808 questionnaires were completed and returned by parents.

Visits

Twenty visits in total were carried out in the period between November 1994 and March 1995 to schools across Scotland; all mainland regions were visited. The first eleven visits were made jointly by two of the research team. Nine visits were made by a single team member. Visits lasted between a half and a whole school day.

The establishments selected for visits were those nominated by either speech & language therapy managers on their original survey questionnaires, or by advisers through subsequent contact (see section on advisers above). Most visits were made to places with 'dual nomination,' from both speech & language therapy managers and advisers in special educational needs. Nominations were invited on the basis of examples of *particular styles or models of service delivery* and examples of *interesting or innovative working practices*, involving the delivery of services to pupils with speech, language and communication difficulties. Not surprisingly, most nominations were for establishments where 'good practice' was perceived to be taking place. Significantly, many of these nominations coincided with establishments where speech & language therapy was being delivered wholly or partly by SLTs funded by Education, through service contracts set up following the Secretary of State's (1991) Initiative.

The visits covered a range of different types of establishments, catering for pupils of all ages and with widely differing types of special educational needs. They included:

- Pre-school, primary and secondary schools
- Schools in rural and urban areas, including significantly deprived areas
- Mainstream schools, special units/classes and special schools

These schools catered for pupils with:

- Specific language impairment
- Physical disability
- Hearing impairment
- Severe & profound complex disabilities
- Autism/pervasive communication disorder
- Learning difficulties
- Delayed language development

Visits consisted of an overview of the school, usually from the head teacher (HT) or assistant head teacher (AHT), and a series of semi-structured interviews. Sometimes there were opportunities for short-term observation in classrooms. Personnel interviewed (usually individually, but occasionally in pairs or small groups) always included a SLT, one or more class teachers, and specialist/learning support teachers where these were involved. Interviews were also conducted with AHTs, language support teachers, classroom auxiliaries, parents and additional SLTs if they were relevant and available.

Eighty-one people in total were interviewed. The interviews were semi-structured, asking for information on the interviewee's background, how they worked with pupils with speech & language difficulties, the extent and nature of collaboration among professionals, and how they saw the role of the SLT. Participants were also encouraged to raise any additional issues of particular importance to them. Most interviews took place in the schools but some were carried out in different locations or on the telephone when personnel were not available in the school at the time of the visit.

Of the 81 people interviewed, there were:

- 24 head teachers, AHTs or senior teaching staff, such as heads of units
- 23 class teachers
- 6 learning support or other specialist teachers
- 2 classroom auxiliaries/assistants
- 3 parents (in addition, a group of parents had participated in a focus group discussion earlier in the study)
- 23 speech & language therapists

The aim of the visits was to provide a degree of external validation to the survey exercise and to gain first hand understanding of:

a) the range of pupils receiving speech & language therapy

b) the ways in which speech & language therapy was being delivered (types/models of service delivery)

c) the issues that concerned SLTs, teachers and parents in day-to-day practice in educational settings

The visits yielded rich information, clarified a number of issues and highlighted particular themes, such as professional development, assessment and programme planning, and the extent to which SLTs worked in the classroom. The information gathered has been used to evaluate the factors (at policy, managerial and day-to-day organisational levels) which may enhance or obstruct the provision of effective speech & language therapy to pupils with special educational needs.

Additional consultations

Contact was made with clinical medical officers through the Scottish Association of Community Child Health, who provided information about the role of their members. In addition, face-to-face and telephone interviews were carried out with a chief adviser within an education department, speech & language therapy and education staff from two Island authorities, and several speech & language therapy managers.

Data analysis

In general, quantitative data have been tabulated and represented as summary statistics. Qualitative data have been analysed for major themes which are described in the text and illustrated, as far as possible, through verbatim quotations.

Presentation

Quotes from surveys and interviews have been included at points throughout this report to illustrate significant themes arising from the data. Where quotes are in italics, these are from our own data. Quotes from other sources are given in plain text.

In quotes from surveys and interviews, continuation marks (…) indicate text has been abbreviated. Any text in square brackets is used: to provide a link between pieces of edited text; to indicate the wording of the question to which the comment relates; or to replace a proper name. In all other respects, quotes are verbatim.

Summary

In this chapter, we have detailed the methods of data collection and analysis employed in the research project, provided an overview of the nature and extent of the project database, and indicated presentational conventions used in this report.

(1) Postal questionnaires were constructed to collect quantitative and qualitative data from the following groups:

- Speech & language therapy managers of services with a remit including children and young people
- SLTs with children/young people on their caseload
- Advisers in special educational needs
- Principal and divisional educational psychologists
- Teachers in special educational facilities and in mainstream nursery, primary and secondary schools
- Parents of children and young people with speech, language and communication difficulties

(2) These questionnaires elicited both quantitative and qualitative data on a *range of issues* which included:

- Numbers of SLT posts and numbers of SLTs in post
- Numbers and types of location in which speech & language therapy services were provided
- Numbers of children and young people receiving speech & language therapy services
- SLTs' caseloads
- Methods of delivery of speech & language therapy services
- Communication among professionals, parents and voluntary organisations
- Numbers of children and young people with Records of Needs whose difficulties included speech, language and communication
- Educational provision and special initiatives for pupils with speech, language and communication difficulties
- Professional development for teachers, SLTs and others
- Parental views on speech & language therapy and educational provision

(3) Managers were asked to nominate education locations which they would recommend as examples of *particular styles or models of service delivery*. These recommendations were used, in conjunction with nominations from advisers in special educational needs, to choose sites for the research team to visit. Rich qualitative data were elicited through visits to 20 schools of a range of types and interviews with a total of 81 staff (SLTs, teachers and others) and parents. Some additional data were collected through telephone interviews and written correspondence.

(4) Numerical data are presented largely in tabular summary form. Qualitative data have been analysed for major themes, which are illustrated in the report through the use of quotations.

CHAPTER 3

Speech & language therapy in Scotland: patterns of provision

Introduction

This chapter looks at the provision of speech & language therapy to children and young people in Scotland. It examines elements of the speech & language therapy service, the size and characteristics of the client group, and the delivery of speech & language therapy to children and young people. Specifically this chapter will consider:

- Numbers of SLTs employed in Scotland and working with children and young people
- Numbers of children and young people receiving a speech & language therapy service, where they are within the service and whether or not they have Records of Needs
- In what locations speech & language therapy is provided
- How speech & language therapy is provided in educational locations

In the main, the information in this chapter is based on analyses of data collected from the postal questionnaires to speech & language therapy managers, SLTs, teachers and parents. See Appendix 5 for copies of the questionnaires, Appendix 1 for additional details of distribution and return rates, and Appendix 2 for more detailed analyses of the data collected from speech & language therapy managers, SLTs, teachers and parents. Where appropriate, comparisons are made with data from research carried out in 1990 by a Working Group of the National Paramedical Advisory Committee (NPAC) (SOHHD, 1993), and data from official sources (ISD Scottish Health Service Common Service Agency, 1995).

Speech & language therapists working in Scotland

As at 31 March 1994, NHS Trusts and Health Boards in Scotland employed:

- 662 SLTs in 545.5 whole-time equivalent (WTE) posts

  10% more SLTs than in the previous year (+10% WTE posts)

  45% more SLTs than in 1990 (205 more than the 457 in post on 31 March 1990)

In addition to SLTs employed by Health Boards and NHS Trusts there were at least another 14 employed by other agencies; this study collected information on 13 SLTs employed by the Scottish Council for Spastics (10.3 WTE posts) and 1 employed in another independent school (1.0 WTE posts). (See Appendix 2.1 for details of SLTs employed in different areas of Scotland.)

The increase of an additional 205 SLTs in post since 1990 is at least in part due to the Secretary of State's (1991) Initiative (see Chapter 1 for an overview of this Initiative). As at 31 March 1994, speech & language therapy managers reported:

- 73.1 WTE posts, and an additional 9.1 WTE vacancies, specifically funded out of the Secretary of State's (1991) Initiative.

Vacancies for SLTs and speech & language therapy assistants exist across Scotland. According to speech & language therapy managers, at 31 March 1994 in Scotland there were:

- 48.4 WTE vacant posts for SLTs
- 6.0 WTE vacant posts for speech & language therapy assistants

The level of SLT vacancies compared to filled posts was 9% in Scotland as a whole. (See Appendix 2.1: Tables 2.1f and 2.1g for further details on vacant posts.)

Speech & language therapy managers reported that there were

- 492 SLTs who worked with children and young people

Most (427) worked mainly or only with this group; only 46 SLTs were noted as working only partly with children and young people. (See Tables (c) – (e) in Appendix 2.1 for more detail on the work patterns of SLTs and speech & language therapy assistants.) Of the 427 who worked mainly or only with children and young people:

- 66% (280) worked on a full-time basis
- 34% (147) worked on a part-time basis

This study received 381 questionnaire returns from SLTs with under-18s on their caseload, which represents 77% of the managers' total of 492 SLTs with under-18s on their caseload.

Speech & language therapy provision in schools

This section is based on data collected from speech & language therapy managers through postal questionnaires. It identifies where speech & language therapy is provided in different educational locations.

Speech & language therapy managers were asked where, in their areas of responsibility, their service provided an on-site speech & language therapy service, and where such a service was required but not being provided. Definitions of on-site provision, and whether a location required such, were constructed with reference to the research carried out by NPAC in 1990 (SOHHD, 1993) to allow comparisons. Locations with on-site provision were defined as:

> Locations where direct and/or indirect speech & language therapy was provided to children and young people during the year 1 April 1993 to 31 March 1994, including locations where blocks of treatment were provided during the year.

Locations where on-site therapy was required were defined as:

(i) Locations with 6 or more children/young people (0–18 years) assessed as requiring regular speech & language therapy.

(ii) Locations with less than 6 children/young people (0–18 years) requiring regular speech & language therapy, with no other reasonable provision (e.g. no clinic within reasonable travelling distance).

(iii) Locations with children/young people (0–18 years) with special needs (e.g. pupils with physical disabilities), where regular contact with a carer/teacher is required, and difficulty in getting to other locations for speech & language therapy.

(iv) Locations that are within an area of environmental deprivation where an on-site service may compensate for non-attendance, even although disorders may not be severe.

(v) Not locations considered to require *more* therapy – only those where *no therapy* was provided and where therapy was required, as defined in (i) – (iv) above.

Speech & language therapy managers noted that they provided an on-site service to a range of schools. Compared with 1990 (SOHHD, 1993), in 1993/94 an on-site service was provided for:

- 298 mainstream nursery schools/classes – 161 more than in 1990 (+118%)
- 924 mainstream primary schools – 137 more than in 1990 (+17%)
- 59 mainstream secondary school – 35 more than in 1990 (+146%)
- 338 special educational facilities – 94 more than in 1990 (+39%)

There has been an overall increase in on-site provision to both mainstream and special educational facilities. Within special educational provision, more establishments in almost every category have received an on-site service. Two types of special educational provision are recorded as having fewer establishments receiving on-site therapy: special educational facilities for pupils with severe/profound learning difficulties (67 in 1990, 53 in 1993/94) and special educational facilities for pupils with pervasive communication difficulties, including pupils on the autistic continuum (14 in 1990, 12 in 1993/94).

The overall pattern of increases is not simply explained. The growth in the provision of on-site speech & language therapy services to schools, units and classes is indicative of increased provision overall. The particular service increases to mainstream schools may reflect a greater focus on integration, and the impact of the Secretary of State's (1991) Initiative.

Although there have been significant increases in the numbers of schools receiving on-site speech & language therapy, managers noted that there were still locations which they knew required on-site therapy but had not received an on-site service in 1993/94. They recorded the following numbers of schools as requiring but not receiving an on-site service.

- 65 nursery schools and nursery classes
- 80 mainstream primary schools
- 36 secondary schools
- 32 special educational facilities

For more detailed data on locations with on-site speech & language therapy and those requiring an on-site service, see Appendix 2.1.

Children and young people receiving a speech & language therapy service in different categories of location

The information in this section comes from questionnaire returns from the 381 participating SLTs. Table 3.1 shows the numbers of different types of locations in which SLTs work, and the numbers of children and young people receiving speech & language therapy in these locations. The numbers do not correspond to those given by managers because the data from SLTs are less complete. However, in some instances the number of locations is actually higher than reported by managers as some locations receive a service from more than one SLT and therefore will have been counted more than once. Similarly, some of the children and young people may have been counted more than once where more than one SLT provided a service to one location, although our questionnaire was designed to minimise the likelihood of this. In fact, in 77% (865) of the locations SLTs did not work with another SLT.

56% of the 20,437 under-18 clients were seen by SLTs in an education setting: 35% in mainstream schools (7,065 pupils) and 22% in special schools, units or classes (4,455 pupils). A significant number of children and young people were also seen in health centres/clinics. In part this reflects an 'early intervention' policy and the fact that around 40% of the under-18s with whom SLTs work fall into the 0-4 years age band (see Table 3.3). Also among those seen in health centres/clinics will be school-aged pupils who live in areas where clinic-based rather than school-based services are provided. (See Appendix 2.1 for more detailed information on the different types of locations in which children/young people received speech & language therapy.)

Table 3.1 Numbers of different types of location in which 381 SLTs work, and numbers of children and young people seen in these locations

Type of location	No. of locations	No. of children & young people
Mainstream schools and nurseries	1,353	7,065
Special schools, units and classes	361	4,455
Locations in Health Board/NHS Trust premises	417	7,140
Locations provided by Social Work Departments	62	332
Other provision (includes provision at home)	640	1,445
Total number of locations and children/young people	*2,833*	*20,437*

Children and young people with and without Records of Needs receiving a speech & language therapy service

Speech & language therapy managers were asked to provide the numbers of children and young people in their service as at 31 March 1994. Data were not available from all managers and some could not give figures in the categories requested: children/young people receiving therapy, those on review, those waiting for assessment, and those waiting for therapy. The numbers of children/young people with Records of Needs within each category were also requested. These data are limited to numbers of children/young people within the service and do not give information on the adequacy of the service provided.

Table 3.2 Children and young people within the speech & language therapy service on 31 March 1994, with and without Records of Needs

Children and young people	With Records of Needs		Without Records of Needs		Total	
Receiving speech & language therapy	**3,428**	(75%)	**11,324**	(43%)	**14,752**	(48%)
On review	**579**	(13%)	**5,446**	(21%)	**6,025**	(20%)
Waiting for assessment	**8**	(<1%)	**1,824**	(7%)	**1,832**	(6%)
Waiting for therapy	**54**	(1%)	**3,441**	(13%)	**3,495**	(11%)
In the service but not known in which category	**498**	(11%)	**4,358**	(17%)	**4,856**	(16%)
Totals	***4,567***	*(15%)*	***26,393***	*(85%)*	***30,960***	*(100%)*

The data received from speech & language therapy managers indicates that *at least* 30,960 children and young people were within the speech & language therapy service on 31 March 1994 and that 15% (4,567) of these were known to have a Record of Needs. Table 3.2 shows where the 30,960 children and young people were within the speech & language therapy service and whether or not they had a Record of Needs.

While these data are almost complete, they are somewhat under-specified because of differences in record-keeping procedures. On the basis of the available information, children/young people with Records of Needs make up around 15% of the under-18 clients within the speech & language therapy service. That only 15% of children/young people within the speech & language service have Records of Needs may seem surprising. The following factors may be relevant. Most children/young people with significant speech, language and communication difficulties will have been referred to speech & language therapy services well before the age of school entry. Consequently, a high proportion of children within the speech & language therapy service are under 5. However, the majority of Records are not drawn up until a child is approaching the age of school entry, although education authorities may draw up a Record of Needs for children from the age of 2. Therefore, some of the young children in the speech & language therapy service who do not have a Record of Needs will have one eventually.

Children/young people with Records of Needs are more likely to fall into the 'receiving therapy' category and are in much smaller proportions in each of the other categories. It is easy to see how the overall impression could therefore be gained that a Record of Needs is a 'passport' to resources. In fact, the direction of causality is not at all clear. Children/young people with Records of Needs are in general likely to have been 'in the system' longer than those without, and this is reflected in the very small numbers of recorded children/young people in the 'waiting for assessment' or 'waiting for therapy' groups. It may also be argued that children/young people with Records of Needs are in general more likely to have severe, complex or persisting needs than those without Records.

Children and young people receiving a speech & language therapy service: gender, age and geographical area

The 381 SLTs who participated in the study noted that they had 21,934 children and young people on their caseloads. In line with epidemiological evidence, boys outnumbered girls by 2:1 (Drillien & Drummond, 1983; Sheridan, 1973; Silva, 1987).

In terms of age, speech & language therapy was focused primarily on pre-school and primary aged children (see Table 3.3). This reflects a professional emphasis on early identification and intervention.

Table 3.3 Children and young people on the caseloads of 381 speech & language therapists in Scotland by age and gender

	0–4 years	5–11 years	12–18 years	Total
Boys	5,707	7,851	1,154	14,712 (67%)
Girls	2,811	3,663	748	7,222 (33%)
Totals	8,518 (39%)	11,514 (53%)	1,902 (9%)	21,934

The figures in Table 3.3 also highlight the low level of provision to secondary aged pupils. In part, this reflects a real reduction in need for speech & language therapy in this age group. However, the figures are particularly striking in relation to the recognition that 80 secondary schools were classed by managers as requiring an on-site speech & language therapy service, while only 59 (74%) received such a service in 1993/94. Identification of the need for additional, appropriate provision of speech & language therapy in secondary settings has been an issue raised by some parents' groups and voluntary organisations in recent years.

Table 3.4 shows the total numbers of children and young people in SLTs' caseloads in different geographic areas, and proportions by age group. Because questionnaire returns were variable across the country, the data available were more complete in some areas than others. The percentages in the first column give the return rate from SLTs in each area. The figures in the second column give the total number of clients on which the percentages of clients in each of the age group were calculated. As can be seen, in some areas secondary school-aged pupils would appear to make up a tiny proportion of those within the speech & language therapy service. This is particularly noticeable in Borders, and Dumfries & Galloway; Orkney also has a low percentage of secondary aged clients.

Table 3.4 Numbers of children and young people on the caseload of 381 SLTs in Scotland by area, and percentages by age and geographical area

Health Board Area	(return rate from SLTs†)	Total no. under-18s on caseloads of participating SLTs	0–4 years %	5–11 years %	12–18 years %
Argyll & Clyde	(50%)	909	34%	54%	12%
Ayrshire & Arran	(100%)	2,274	38%	55%	7%
Borders	(69%)	505	32%	65%	3%
Dumfries & Galloway	(100%)	985	54%	42%	4%
Fife	(50%)	735	38%	49%	14%
Forth Valley	(85%)	1,515	37%	56%	7%
Grampian	(85%)	2,417	41%	54%	6%
Greater Glasgow	(58%)	2,908	42%	42%	17%
Highland	(78%)	1,352	31%	62%	7%
Lanarkshire	(85%)	2,399	41%	50%	9%
Lothian	(86%)	2,828	41%	51%	8%
Tayside	(100%)	2,102	43%	51%	7%
Orkney	(100%)	646	9%	90%	1%
Shetland	(100%)	126	35%	60%	5%
Western Isles	(80%)	142	20%	71%	9%
SCS & other*	(43%)	78	39%	33%	28%
Independent¥	(100%)	13	23%	69%	8%
Totals	*(77%)*	*21,934*	*39%*	*51%*	*9%*

† Proportion of SLTs known to work with children/young people who returned questionnaires
* Scottish Council for Spastics and one other independent school
¥ SLTs working independently but attached to universities/colleges

The 21,934 children and young people constitute half of the 43,730 clients aged 0–18 years seen by the speech & language therapy service in the year ending 31 March 1994, as calculated from official ISD figures. The ISD figure is very much higher because it includes not only those under-18s seen by SLTs who did not participate in the present study but also those assessed but not treated, and those discharged in 1993/94.

Prioritisation of caseloads

SLTs were asked how they prioritised their own caseload. 82% of the 381 SLTs indicated that they did prioritise their work. However, only 7% (26) indicated that they prioritised their caseload with reference to a service policy or set of guidelines. 2% (7) explicitly mentioned that they worked to the guidelines in 'Communicating Quality' (CSLT, 1991) and less than 1% (4) noted that a policy was under construction or being piloted.

44% noted that they prioritised their work on the basis of 'need' or 'severity of disorder' and/or a mixture of other factors, including age, prognosis and available support. These SLTs often stated that they made decisions on the basis of their 'professional judgement'. 23% said that they prioritised on the basis of a particular disorder or client group; often this was related to the age of the client, such as 'pre-school children.' 19 SLTs (5%) specifically stated that children with Records of Needs were given priority.

How speech & language therapists work and collaborate in different types of school

The remainder of this chapter, based on the data from SLTs', teachers' and parents' questionnaires, describes the way in which SLTs work, and their relationships with parents and other professionals, in each of 8 types of educational facility:

- Mainstream nursery schools and classes
- Mainstream primary schools
- Mainstream secondary schools
- Special educational facilities for pupils with learning difficulties
- Special educational facilities for pupils with specific language disorder (language units)
- Special educational facilities for pupils with pervasive communication disorder/autism
- Special educational facilities for pupils with hearing impairment
- Special educational facilities for pupils with physical difficulties

Returns received on children/young people in educational facilities for pupils with visual impairment and for pupils with emotional and behavioural difficulties were too few to allow meaningful conclusions to be drawn.

Speech & language therapists

In our surveys, SLTs were asked how they delivered direct and indirect speech & language therapy and who they worked *with* (direct speech & language therapy) and *through* (indirect speech & language therapy). The data presented are from the 381 SLTs working with under-18s as described above.

Teachers

Teachers in all types of educational location were asked how their pupils received speech & language therapy and about the contact they had with SLTs. 818 teachers participated in the research. However, their descriptions of the schools in which they worked did not all fit neatly into one of the eight categories of educational facility used for the analyses which comprise the remainder of this chapter. For example, some worked in special educational facilities which catered for pupils with a variety of difficulties, such as pupils with physical disabilities and pupils with learning difficulties. Only data from the 715 teachers who were identified within specific types of educational facility have been included, and in most cases only data from the 393 teachers with pupils in their classes receiving speech & language therapy are considered. The numbers of teachers in different types of location who returned questionnaires and, of those, how many had pupils in their classes known to be receiving speech & language therapy, are shown in Table 3.5.

Table 3.5 Numbers of teachers in different types of educational setting returning postal questionnaires, and numbers of teachers with pupils receiving speech & language therapy

	All teachers	Teachers with pupils receiving speech & language therapy
Mainstream settings		
Nurseries and nursery classes	46	42
Primary schools	336	171
Secondary schools	78	25
Special educational settings		
Schools/units/classes for pupils with…		
learning difficulties	164	144
specific language disorder (language units/classes)	11	11
pervasive communication disorders/autism	5	5
hearing impairment	24	22
physical disabilities	17	8
visual impairment	9	5
emotional and behavioural difficulties	30	2
Totals	*715*	*391*

Parents

Parents of both boys and girls with very different types of problems participated in the research. These families were diverse in terms of social class, and they included some single parents (60; 12%) although in smaller proportion than might be expected given recent trends. Where the sample is lacking is in returns from parents from ethnic minority backgrounds: only 8 questionnaires were returned from parents where one or both was identified as belonging to an ethnic minority group. To get a true picture of the situation for ethnic minority children a project based on interviews rather than postal surveys would be needed. On some of the visits, particular problems related to ethnic minority children were raised by SLTs and teachers. These included difficulties experienced by professionals in communicating with parents, particularly mothers.

Parents were asked about their children's education and their children's speech & language therapy. 520 parents returned questionnaires but only 389 had children within a particular type of educational location. Several of the parents excluded from the analyses had pre-school children who did not attend a nursery. The numbers of parents with children in different types of educational location are shown in Table 3.6.

Table 3.6 Numbers of parents returning postal questionnaires by children's educational setting

	No. of children/young people*
Mainstream settings	
Nurseries and nursery classes	76
Primary schools	96
Secondary schools	11
Special educational settings	
Schools/units/classes for pupils with...	
learning difficulties	140
specific language disorder (language units/classes)	44
pervasive communication disorders (including pupils who may be described as autistic)	5
hearing impairment	3
physical disabilities	13
visual impairment	1
emotional and behavioural difficulties	0
Total	*389*

* Each returned parent's questionnaire related to one child. On a few occasions parents completed more than one form if they had more than one child with difficulties.

Across all types of educational facility, although there were parents who were dissatisfied with their children's education or with their children's speech & language therapy, a surprisingly large proportion of parents reported satisfaction with elements of both. Moreover, positive responses came both from parents who requested questionnaires and from those who received forms from SLTs. The questionnaire returns suggest that parents may have had to 'fight' to get what they regard as an appropriate service for their children, but having achieved this, or something close, they are appreciative of the service, even if they would like 'more.'

> *"For many years I have had to fight the system to make sure that my daughter receives what she is entitled to .... Previously the speech therapist refused to go into the school or allow school staff to attend sessions. I had to act as a go-between. The new speech therapist, however, happily works with all concerned."*

Although some of the analyses may indicate what parents like about the education and speech & language therapy their children receive, this should not obscure the fact that some parents are still struggling to achieve what they regard as an acceptable standard of provision. Nor should it obscure the fact that most parents would appreciate more of what they recognise as beneficial for their children.

A framework for describing how speech & language therapists work in different types of schools

The sections which follow describe the type of speech & language therapy service which is most characteristic of each of eight types of educational facility. These descriptions focus mainly on the nature and extent of collaborative practice between SLTs and other professional staff (especially teachers), and on parents' views of their children's educational and speech & language therapy provision.

Survey returns from SLTs indicate the numbers of SLTs working, and the numbers of pupils receiving speech & language therapy services, in each category of educational facility, and provide data on the overall number of children/young people on the caseloads of SLTs working in such settings. As relatively few SLTs work in only one type of location, and even fewer work in only one location, an indication is also given of the typical number of locations in which individual SLTs worked. For each type of school, the description reports the percentage of SLTs who sometimes worked jointly with teachers as part of a programme of therapy, and the percentage of SLTs who *always* worked on their own in direct work with pupils. Also reported is the percentage of SLTs who collaborated with other staff in activities not involving direct contact with pupils, such as the planning of educational or speech & language therapy programmes. These data are presented in terms of the percentages of SLTs indicating that they worked in particular ways in the different types of educational setting[5]. A summary of relevant findings is presented in the from of a diagram at the beginning of each section.

The incorporation of information from teachers' and parents' surveys provides different perspectives on the patterns of speech & language therapy services across the range of types of educational facility.

Since much of the discussion which follows focuses on issues of collaboration, and since collaboration means different things to different people, operational definitions of some relevant professional activities are given in the following box. (These issues are discussed in more detail in Chapter 6.)

Collaboration: some definitions

Direct speech & language therapy involves SLTs in direct, face-to-face work with a client (**one-to-one therapy**) or with a group of clients (**group therapy**). In the present study, SLTs were asked to distinguish among direct therapy which took place (a) in the classroom, (b) in school but not in the classroom (where pupils are withdrawn from class) and (c) in another setting (i.e. not in school). Direct therapy may be provided by a SLT working alone or in collaboration with other staff, and with or without the direct involvement of parents/carers.

Indirect speech & language therapy includes a wide range of professional activities which are client-related but which do not involve face-to-face contact with clients, although they may involve contact with staff, parents and significant others in a client's environment. Collaboration in this context may be described as **working through others** in order to achieve speech & language therapy goals. Preparation of programmes and materials, liaison with parents, discussion and joint planning with teachers or others working with a client, participation at case conferences and providing staff training are all examples of indirect speech & language therapy.

Collaboration is used in this report as an umbrella term to cover all types of situations in which a professional works jointly with, liaises with or otherwise includes other people who are in a client's environment in order to achieve educational or speech & language therapy aims. Collaboration includes direct face-to-face work with a client or indirect input to, or manipulation of, the client's environment.

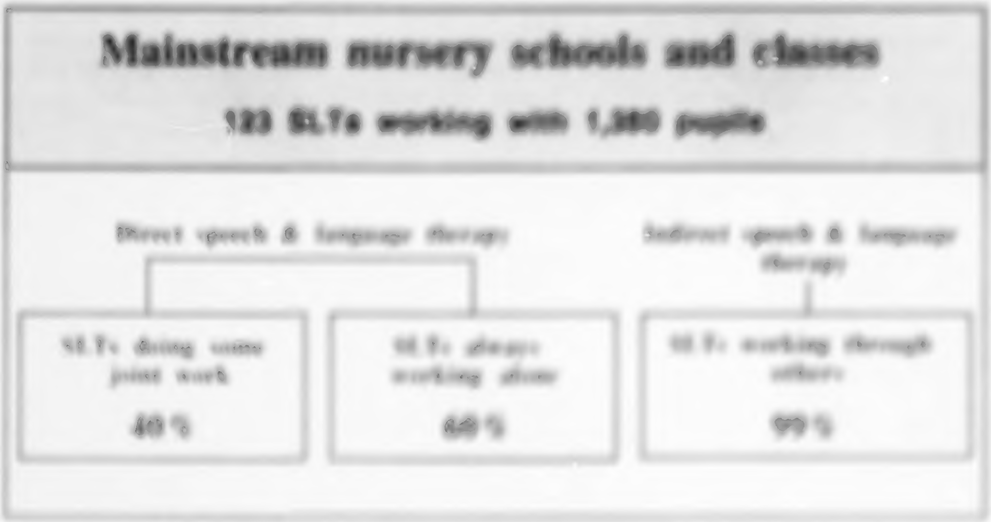
Joint planning is when SLTs, teachers and/or other education staff spend time together preparing individualised educational and/or speech & language therapy programmes. (These are 'indirect' therapy/teaching activities.)

Joint working, for the purposes of this report, is when SLTs, teachers and/or other education staff spend time together working directly with pupils, whether in the classroom or in any other location.

Descriptions of the nature and extent of collaboration in each type of educational setting follow.

---

[5] For the purposes of this chapter, numbers of SLTs refer to *people* rather than to whole-time equivalents. It was not practicable to ask SLTs to calculate the amount of time spent in each of the locations in which they worked in terms of WTEs.


Mainstream nursery schools and classes
123 SLTs working with 1,380 pupils
Direct speech & language therapy
Indirect speech & language therapy
SLTs doing some joint work
40 %
SLTs always working alone
60 %
SLTs working through others
99 %

Speech & language therapists and mainstream nursery schools/classes

123 SLTs providing a service to 1,380 children in nursery schools and classes reported how they worked in this type of setting. However, these 1,380 children receiving speech & language therapy in nursery schools and classes accounted for only 16% of the under 5s on the caseloads of all 381 SLTs who participated in the study. It was far more common for children of this age group to receive their speech & language therapy in a clinic or other setting[6].

Only 3 of these 123 SLTs worked exclusively in mainstream nursery settings. The median[7] number of total locations in which the 123 SLTs worked was 10 (80% covered between 4 and 24 different locations). Across all of these locations, SLTs worked with caseloads of different sizes: the median caseload of under 18s[8] was 63, with 80% of SLTs having between 22 and 122.

- 40% of the SLTs worked jointly with teachers and other professionals in the delivery of direct speech & language therapy. Joint working was carried out with individual children and with groups, both inside and outside the classroom.
- 60% of the SLTs worked always their own and not jointly with other professionals.
- All but one of the 123 SLTs working in nurseries worked indirectly through other professionals, support staff and parents.

---

[6] Other settings include health centres and clinics, special educational facilities, social work sponsored children's centres and the children's own homes.

[7] Since, for both locations and caseloads, the range of values contains a small number of very large values which would lead to a misleading average if mean values were calculated, we have used median values in order to communicate 'typical' values. (The median is the value which has as many scores above it as below it. It is not influenced by a few atypical scores at either end of the scale.)

[8] The caseload figures reported here refer only to under 18s: some SLTs will also have adult clients on their caseload.

Much of the SLTs' collaboration involved discussions and planning with teachers, attending case conferences and meetings, and training education staff. Most SLTs noted that they worked with or through nursery nurses, class teachers, classroom auxiliaries and parents. Also, in most nurseries SLTs indicated that the speech & language therapy programmes of at least some of the children were continued when the SLT was not present.

Teachers and mainstream nursery schools/classes

43 teachers in mainstream nursery settings with pupils in their class receiving speech & language therapy returned questionnaires. In general, teachers' reports reflected the same pattern of speech & language therapy provision as SLTs'. In addition:

- 19% reported they had ***regular, timetabled contact*** with a SLT.
- 53% had ***informal contact*** with SLTs such as during coffee breaks, or contact at the request of themselves or the SLT.
- 28% reported ***no contact*** at all with SLTs.

It is likely that these finding are closely related to the fact that more nursery-aged children received speech & language therapy outside the nursery than did in the nursery.

- 63% of these 43 teachers indicated they would have liked to have more formally allocated time for liaison with SLTs.

Parents and mainstream nursery schools and classes

Parents liked particular features of the education their children were getting in mainstream nurseries. These features included small classes and group work, mixing with local children and mixing with more able children. However, several parents also felt that their children would benefit from changes. For example, they noted the need for more understanding of their children's difficulties and for more support staff:

> *"[My child's] speech is improving and she is getting to know local children and they are getting to know her ... [Her education could be better with] better support staff who are trained to work with children who have special needs."*

In terms of speech & language therapy, many parents mentioned the good relationships their children had with their SLTs and the progress their children had made through small group work:

> *"The therapist motivates my child by playing games and making it fun to learn ... I don't think she could get better [speech & language therapy]."*

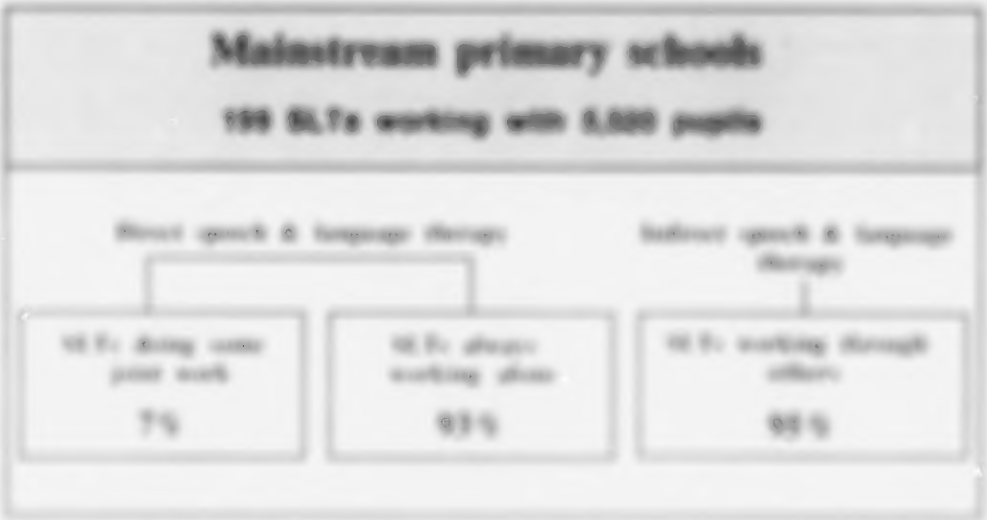
> *"One of the good things is that [my child] really looks forward to going to [speech & language therapy]; she likes Mrs [X] her therapist ..."*

Several felt they would like more information from the SLT. A number of parents were generally happy with their children's education and speech & language therapy and wanted more of what they saw to be good for their children:

> *"I don't think the quality [of my child's speech & language therapy] could be any better than what she is receiving just now, just more of it would be good."*

However, other parents were not so happy. Some did not comment on what could improve their children's education and speech & language therapy, while others were more specific about what they wanted:

> *"[Children's education could be better] if there were more places available in language units and parents did not have to fight for what is their child's entitlement to be educated."*


Mainstream primary schools
199 SLTs working with 5,000 pupils
Direct speech & language therapy
Indirect speech & language therapy
SLTs doing some joint work
7%
SLTs always working alone
93%
SLTs working through others
95%

Speech & language therapists and mainstream primary schools

Typically, a SLT who works with primary school pupils covers a number of primary schools; 90% of these 199 SLTs worked in between 1 and 10 primary schools; the median was 4. Moreover, the 'typical' SLT covered a range of different locations as well as mainstream primary schools – 90% worked with children/young people in between 4 and 21 locations overall; the median was 9.[9]

The total number of children/young people across all locations on the caseload of a typical SLT working in mainstream primary schools was around 60, with 90% having between 22 and 127 children/young people on their caseloads. Of the 199 SLTs working in mainstream primary schools, the highest overall caseload was 808.

There was some evidence of a range of collaborative practices:

- 95% of the 199 SLTs working in mainstream primary schools reported that they worked indirectly through other staff.

In the main, however, pupils in mainstream primary schools receive direct speech & language therapy in a traditional way. In most schools pupils are withdrawn from class and work with the SLT on their own or in groups with other pupils with communication difficulties, who may or may not be in their classes.

- In the vast majority of primary schools (89% schools; 93% SLTs) tended to work on their own with individual pupils withdrawn from the classroom; 98% of pupils were noted to receive some or all of their therapy in this way.

- 40% of the 199 SLTs reported that they provided neither direct nor indirect speech & language therapy with any other staff; these SLTs worked in 330 schools with 2,019 pupils.

---

[9] Where a SLT also works with adults, the overall number of locations in which she works may be even greater.

- In only a tiny minority of primary schools was joint working in the delivery of direct speech & language therapy to pupils reported: 7% of the SLTs reported direct work jointly with other staff in 14 primary schools.

- 13% (29 SLTs working in 90 schools) reported that they worked neither directly nor indirectly with class teachers and 34% (67 SLTs in 263 schools) reported that they worked neither directly nor indirectly with learning support teachers.

Teachers and mainstream primary schools

From our questionnaire returns, 171 mainstream primary teachers reported having one or more pupils in their classes who were known to be receiving speech & language therapy. These teachers noted that 98% of their pupils received their speech & language therapy on a regular or occasional basis in the school but withdrawn from the classroom.

Table 3.7 Mainstream primary teachers' contact with speech & language therapists: 171 mainstream primary teachers with pupils they knew to be receiving speech & language therapy in the Spring term of 1996

Type of contact	% of teachers*	N
Reporting & feedback		
• Teacher reported or gave feedback (verbal or written) to the SLT on educational programme and/or assessment	46	171
• SLT reported or gave feedback to teacher (verbal or written) on therapy assessment results and progress	70	167
Observation		
• SLT has observed classroom work	19	155
• Teacher has observed SLT working with pupils	25	151
Joint work and joint planning		
• Teacher and SLT work together in the classroom with individuals or groups of pupils	6	161
• Teacher and SLT plan together educational programme (or part of programme)	9	152
• Teacher and SLT plan together speech & language therapy programme (or part of programme)	13	157
Guidance and advice		
• Teacher offered guidance and advice to SLT	25	151
• SLT offered guidance and advice to teacher	50	163

* Numbers do not necessarily correspond as more than one type of contact was possible

Table 3.7 shows the number of teachers and the type of contact they had with SLTs. Most often, mainstream primary teachers reported that their contact with SLTs involved receiving reports and feedback and/or guidance and advice from SLTs. The low levels of joint observation, joint planning or joint work with pupils are striking. Only a very small percentage (6%) reported joint working with SLTs directly with pupils.

Not all teachers reported how they had contact with SLTs, but of those who did:

- Only 5% reported **regular, timetabled, one-to-one contact** with a SLT
- 66% noted that they had only **informal contact** with SLTs, such as during coffee breaks, or contact at the request of themselves or the SLT
- 27% reported that they had **no contact** with SLTs

- 67% would have liked to have more formally allocated time for liaison with SLTs

Parents and mainstream primary schools

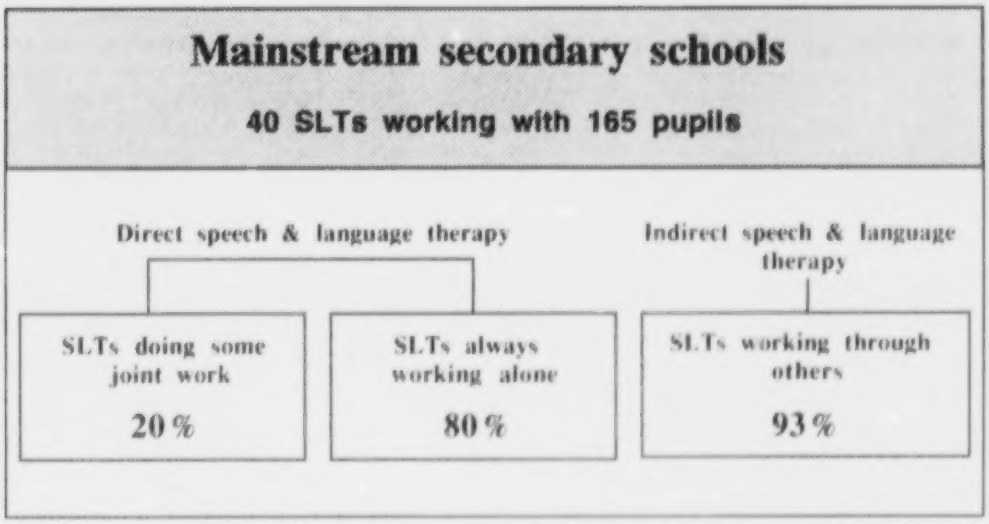
96 parents with children at mainstream primary schools returned questionnaires. They varied in what they had to say about their children's education and speech & language therapy. Often they liked elements of what may only be possible in a mainstream setting – their children mixing with other local children:

> *"My child is learning to mix with other neighbourhood children and all things that go with that. My child is treated equally with the other children but does have extra help with learning support, special educational teachers."*

However, where it was possible to have a child in a mainstream setting *and* for their child to get the support needed (even if this demanded a 'split placement', whereby a child attended two different schools on a part-time basis), a high level of parental satisfaction was expressed:

> *"Because our son attends the language unit each morning where numbers are small he gets individual attention and help in the areas he most needs. He is able to work with extremely supportive staff on a one to one basis and also in small groups … Each afternoon he attends his mainstream primary where help is given as needed. He mixes in a much larger group and experiences 'normal' school life. He has the 'best of both worlds'."*

Mainstream secondary schools


Mainstream secondary schools
40 SLTs working with 165 pupils
Direct speech & language therapy
Indirect speech & language therapy
SLTs doing some joint work
20%
SLTs always working alone
80%
SLTs working through others
93%

Speech & language therapists and mainstream secondary schools

40 SLTs stated that they provided a service to 165 pupils[10] in 68 secondary schools[11]. This number of schools constitutes only 15% of all secondary schools in Scotland.

Most of these SLTs saw only a small number of secondary school pupils in school, and went into only one secondary school, rather than seeing pupils in several secondary schools. All these SLTs worked across a range of other locations. Most worked in between 7 to 22 locations: the median was 12. The median number of under-18s on the caseloads of these SLTs was 56, with 90% having between 18 and 116.

Given the widespread recognition that provision of speech & language therapy to secondary schools is poor overall, it is interesting to note that almost all SLTs indicated that they were working collaboratively.

- Almost all of the SLTs (37; 93%) worked indirectly through other professionals or support staff in the secondary schools, most often through learning support teachers, but also through class teachers and classroom auxiliaries/assistants.

Some SLTs were working directly with pupils jointly with other staff.

- 20% of the SLTs described themselves as providing direct speech & language therapy to pupils jointly with another professional
- 80% reported always working alone in the provision of direct speech & language therapy to individuals or groups of pupils

---

[10] The number of secondary school aged pupils receiving speech & language therapy *in school* is significantly smaller than the overall number of secondary school aged pupils receiving speech & language therapy (see Table 3.3). The explanation is that secondary school pupils are more likely to receive their therapy outwith the school premises, such as in a health centre or clinic.

[11] This number is greater than the 59 schools recorded by managers as receiving an on-site service. In addition to the one manager's questionnaire not returned, this may reflect recognition by managers that service to secondary schools is often too infrequent to be described as 'on-site.'

Learning support teachers and mainstream secondary schools

78 learning support teachers[12] in mainstream secondary schools returned completed questionnaires. However, less than one-third of these teachers worked with pupils whom they knew to be receiving speech & language therapy (25 learning support teachers; 32%).

These 25 learning support teachers worked with 105 pupils receiving speech & language therapy. More than half of these pupils were in just 3 schools (59 pupils; 56%), therefore any conclusions based on these data must inevitably be constrained. As in mainstream primary schools, many pupils received their speech & language therapy in the school but withdrawn from the classroom. Others received therapy in the classroom, individually or in groups. Not all of the learning support teachers reported how their pupils received therapy and some noted that they were unsure.

- 52% of these secondary pupils received speech & language therapy ***in school but withdrawn from the classroom***
- 20% of these secondary pupils received speech & language therapy ***in the classroom***, mostly in groups
- 11% of these secondary pupils went ***out of school*** for speech & language therapy

The contact between the 25 learning support teachers and SLTs varied from no contact at all to regular, timetabled contact.

- 12% secondary learning support teachers had ***regular, timetabled, one-to-one*** contact with SLTs
- 56% secondary learning support teachers had ***informal contact*** or contact only on request by themselves or by the SLT
- 32% secondary learning support teachers had ***no contact*** with SLTs
- 68% of these teachers stated that they would like more formally allocated time for liaison with SLTs

Several of the learning support teachers commented that while speech & language therapy was targeted at pre-school children and primary pupils, they felt that secondary pupils should get more provision. Moreover, their comments indicated recognition of a lack of knowledge about language on the part of teachers and a need for training. Comments included:

> *"There is a continual problem of lack of time. The SLT seems to have a heavy caseload with emphasis being placed on infants/young children. Often our children are 'monitored' i.e. they should have speech therapy and indeed this may be stated in their Records of Needs but have no direct 1:1 input of a sustained period of time. Too many teachers believe speech therapists deal only with poor pronunciation."*
>
> (Learning support teacher, secondary school)

> *"I feel very strongly that youngsters would continue to benefit from speech & language therapy* [in secondary school] *... I try as much as I can but I am neither trained nor sure of what I'm doing (I'm afraid I may do more harm than good)."*
>
> (Learning support teacher, secondary school)

---

[12] The sample of teachers did not include subject teachers in mainstream secondary schools.

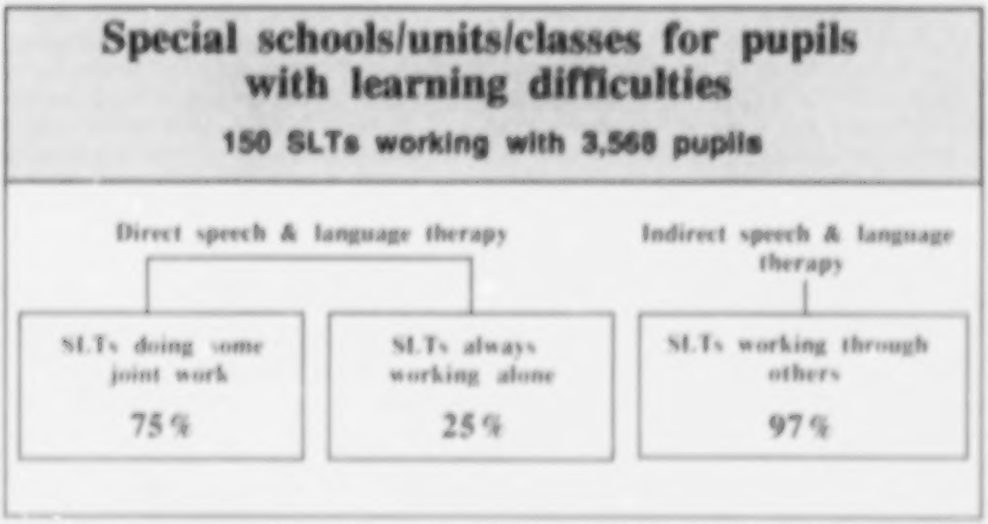
Parents and mainstream secondary schools

Only 11 parents with children at secondary schools returned questionnaires. Their comments about their children's education were generally positive but in the main they particularly appreciated the special provision that was available. They noted that they valued the one-to-one and small group work their children got, work which was specially geared to their needs. A few parents mentioned that they thought it good that their children were able to mix with more able pupils:

> "[My child] *gets a good mixture of 1 to 1, small group and mainstream class and has made good progress with this* … [if] *the speech therapist had strong links with the staff at the school* [it] *would help … with her interaction. I would like to emphasise the importance of working as a team with parents, staff and anyone else involved in a child's education, also the flexibility to work in child's familiar environment …*"

In terms of speech & language therapy, parents were perhaps less satisfied, but mainly because they would like more therapy. Two parents noted that they thought SLTs should spend more time in school with their children. In the words of one of these parents:

> *"The therapist seems to understand my daughter's capabilities very well and uses equipment best suited to her, never trying to use things that she knows are beyond her reach, but still encouraging her to improve herself all the time. At present, with this speech therapist, things seem to be working well, as she is willing to consult with teachers etc. But this was not the case with her last speech therapist, and I would hate to see it happen again. Speech therapists should always spend some time in the child's school."*



Special schools/units/classes for pupils with learning difficulties

150 SLTs working with 3,568 pupils

Direct speech & language therapy
Indirect speech & language therapy
SLTs doing some joint work
75%
SLTs always working alone
25%
SLTs working through others
97%

Speech & language therapists and special educational facilities for pupils with learning difficulties

Information on working in schools for pupils with learning difficulties was provided by 150 SLTs working with 3,568 pupils. The median under-18 caseload of this group of SLTs was 52: most had a caseload of between 22 and 127. The highest caseload was 229.

Most of the 150 SLTs worked in between 1 and 3 facilities for pupils with learning difficulties, and a range of other locations as well, although 10% worked with children/young people only in this setting. Overall, most worked in between 1 and 21 different locations: the median was 7.

In the main, the way SLTs described their work in these establishments indicated a high level of collaborative practice.

- 97% of the SLTs noted that they worked indirectly through other professionals and support staff
- 75% of the SLTs worked directly with pupils jointly with other professionals and support staff. They worked with individuals and groups of pupils both in and outside the classroom[13]:
    - 31% of the 150 SLTs worked jointly with other staff with **individual** pupils ***in*** the classroom
    - 25% worked jointly with other staff with **groups** of pupils ***in*** the classroom
    - 23% worked jointly with other staff with **individual** pupils ***withdrawn*** from the classroom
    - 25% worked jointly with other staff with **groups** of pupils ***withdrawn*** from the classroom

---

[13] More than one type of joint work tended to be undertaken by individual SLTs and so the percentages given for the 4 categories of joint work are not mutually exclusive.

Many SLTs described themselves as working directly with and indirectly through class teachers and classroom auxiliaries/assistants. Several also said they worked with other SLTs and some worked with speech & language therapy assistants. The numbers of SLTs and the professionals and support staff with whom they work are shown in Table 3.8.

- 25% of the 150 SLTs reported that they always worked alone delivering direct speech & language therapy to pupils.

Table 3.8 Speech & language therapists working with other professionals and support staff in special educational facilities for pupils with learning difficulties: sample of 150 SLTs

	SLTs collaborating with other staff*	
	Collaboration including joint working directly with pupils	*Collaboration excluding joint working directly with pupils*
Class teacher	62% (93)	24% (36)
Classroom auxiliary/assistant	42% (63)	17% (25)
Nursery nurse	25% (37)	7% (10)
Other SLT	17% (25)	9% (13)
Learning support teacher	8% (12)	6% (9)
Speech & language therapy assistant	7% (11)	3% (5)
Occupational therapist	7% (11)	6% (9)
Educational psychologist	3% (4)	29% (43)

* *Numbers are not mutually exclusive as SLTs tend to collaborate with a range of other professionals*

Class teachers represent the group with whom SLTs are most likely to collaborate in this setting. It is therefore striking that 14% of SLTs failed to report ***any*** collaboration with class teachers. 59% of SLTs report collaboration with classroom auxiliaries or assistants; this is therefore a significant group in terms of educational support for speech, language and communication programmes.

In addition, SLTs thought that in many schools speech & language therapy programmes were continued when they were not there. In 30% of their schools, SLTs noted that speech & language therapy programmes were continued with *all* pupils, and in a further 58% of their schools that programmes were continued with at least some of the pupils or for some of the time. Those who most often carried out programmes in the SLTs' absence were class teachers and classroom auxiliaries.

Teachers and special educational facilities for pupils with learning difficulties

144 teachers in special educational facilities for pupils with learning difficulties returned questionnaires; they had 815 pupils in their classes who were receiving speech & language therapy. 23% of these pupils always received speech & language therapy outside the classroom, either in the school or at a clinic (188 pupils).

- 40% of the teachers reported joint working with SLTs. Returns from these teachers therefore mirrored those of SLTs in indicating a higher level of collaborative practice than was found in mainstream settings.

The contact teachers had with SLTs, including joint working, is shown in Table 3.9. The frequency of contacts of all kinds is markedly higher than was seen for mainstream primary schools. Moreover, there is more evidence of a two-way exchange of information, with teachers informing SLTs as well as the other way round, even if exchanges are rather more commonly in the direction of SLT to teacher. There is also a very much higher level of joint planning of programmes, as well as joint work with pupils.

Table 3.9 Special educational facilities for pupils with learning difficulties: teachers' contact with SLTs; 144 teachers who had pupils known to be receiving speech & language therapy in the Spring term of 1994

Type of contact	No. of teachers*	%
Reporting & feedback		
• Teacher reported or gave feedback (verbal or written) to the SLT on educational programme and/or assessment	91	63%
• SLT reported or gave feedback to teacher (verbal or written) on therapy assessment results and progress	119	83%
Observation		
• SLT has observed classroom work	88	61%
• Teacher has observed SLT working with pupils	66	46%
Joint work and joint planning		
• Teacher and SLT work together in the classroom with individuals or groups of pupils	57	40%
• Teacher and SLT plan together educational programmes (or part of programme)	47	33%
• Teacher and SLT plan together speech & language therapy programmes (or part of programme)	63	44%
Guidance and advice		
• Teacher offered guidance and advice to SLT	72	50%
• SLT offered guidance and advice to teacher	111	77%

*Numbers are not mutually exclusive as teachers often reported more than one type of contact

Unlike the reported patterns in mainstream, teachers in these special educational facilities reported that many pupils received speech & language therapy in more than one way. As Table 3.10 shows, more than half of all pupils who were getting speech & language therapy were receiving it in a group in the classroom. More than one-third of pupils were withdrawn from class for therapy but most (188 pupils) were also receiving therapy in class. This represents a higher level of classroom-based speech & language therapy than was found in mainstream schools.

Table 3.10 Numbers of pupils in special educational facilities for pupils with learning difficulties who received speech & language therapy in different ways

	No. of pupils[a]	% of 815 pupils[a]
Regular (weekly or monthly) speech & language therapy		
One-to-one therapy in the classroom	153	19%
Therapy in a group in the classroom	471	57%
Therapy in the school but outside the classroom	317	39%
Therapy outside the school	24	3%
Occasional speech & language therapy		
One-to-one therapy in the classroom	38	5%
Therapy in a group in the classroom	41	5%
Therapy in the school but outside the classroom	87	11%
Therapy outside the school	17	2%

[a] Numbers are not mutually exclusive as pupils very often received therapy in more than one way

Most teachers said they had some one-to-one contact with a SLT; however, a few (10.7%) of those with pupils receiving speech & language therapy did report having no one-to-one contact. Table 3.11 shows the type of contact teachers had with SLTs.

Table 3.11 Numbers of teachers in special educational facilities for pupils with learning difficulties who had different types of one-to-one contact with speech & language therapists

	No. of teachers[a]	%[a] (of 144 teachers)
Regular, timetabled one-to-one contact	33	23%
Regular but informal contact, for example, during breaks or at the end of the day	96	67%
Occasional one-to-one contact at the request of the teacher	44	31%
Occasional one-to-one contact at the request of the SLT	44	31%

[a] Numbers are not mutually exclusive as more than one type of contact was possible

The proportion of teachers in special educational facilities who had formalised contact with SLTs was higher than in mainstream settings, although 33 teachers still only constitutes about one-quarter (23%) of the 144. Most contact was still on an informal or 'on request' basis. More than 40% of teachers wanted more formal arrangements or more formally allocated time for liaison with SLTs.

Parents and special educational facilities for pupils with learning difficulties

140 parents of children/young people in special educational facilities for pupils with learning difficulties returned questionnaires. Most parents felt that class teachers and SLTs understood their children's difficulties. Only 3 parents felt that no-one understood their children's difficulties.

Almost without exception parents mentioned 'small classes' as something that was good about their children's education. Other positive characteristics included work tailored for the children's needs, the opportunity to mix with children with similar difficulties and, conversely, the opportunity to mix with more able children:

> *"*[Good things about my child's education are] *small class, varied curriculum suited to child's needs … opportunity to integrate* [although] *limited to musical movement and playground activities, access to technology, concept keyboard etc.* [her education could be better with] *perhaps more training for auxiliary staff … more social integration."*

> *"The class is small. All the other children have different needs, which means he is also working with more able bodied children, which he seems to enjoy."*

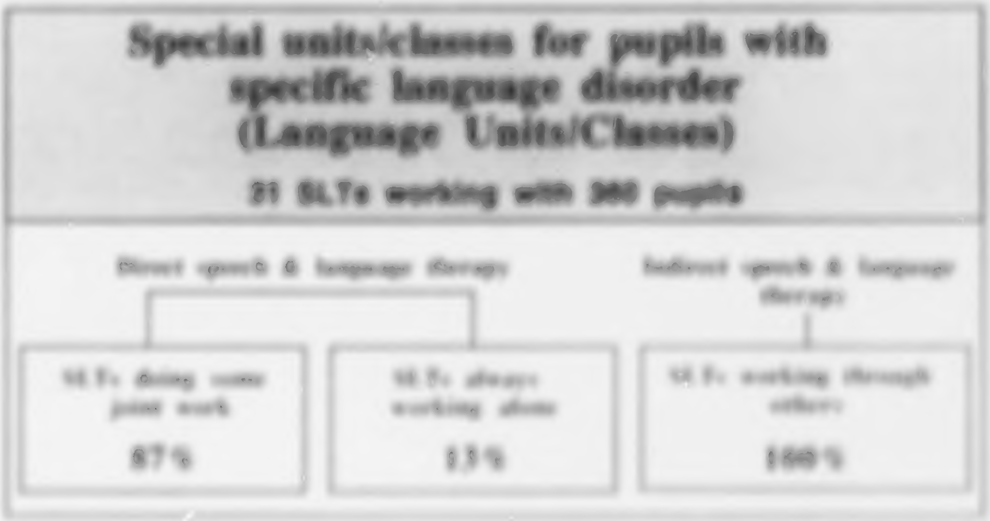
Like parents with children in all types of schools, parents with children in facilities for pupils with learning difficulties were often happy with the speech & language therapy their children were receiving but wanted more. Many parents mentioned small group work as of particular benefit to their children:

> *"My child enjoys his therapy session. Group work and block therapy gives child a break from intense sessions.*[One of the good things about the therapy he is getting is] *therapy being an integral part of his class routine …* [My child's therapy could be better if there was] *more of it."*

In the following quote, one parent highlighted a particular problem related to recruitment and retention of staff – this problem was not restricted to one type of educational facility but it appeared to be a particular concern of parents whose children had relatively 'long term' and persisting difficulties, and therefore was more apparent in the returns relating to special educational facilities:

> *"Class teacher and myself continue speech & language work despite minimal involvement of therapist … My child's therapy would be much improved if there was a regular therapist. She has seen 3 or 4 therapists over the last 18 months or so and has not had regular therapy* [for several months]. *Locums are perhaps better than nothing but do not provide continuity or the opportunity to build a relationship with child."*

Special educational facilities for pupils with specific language disorder ('language units/classes')


Special units/classes for pupils with specific language disorder (Language Units/Classes)
31 SLTs working with 360 pupils
Direct speech & language therapy
Indirect speech & language therapy
SLTs doing some joint work
87%
SLTs always working alone
13%
SLTs working through others
100%

Speech & language therapists and language units/classes

31 SLTs provided information on how they worked with 360 pupils in this setting. These SLTs had a median caseload of 10 language unit/class pupils, and 36 children/young people in total across all locations. These figures are much lower than those seen in the settings already described. Most of the 31 SLTs had between 6 and 21 language unit/class pupils on their caseload and between 11 and 78 children/young people in total across all locations. 16% (5) worked with children/young people in no other setting. The number of locations in which these SLTs worked was also lower than those seen previously. Hardly any covered more than 2 units, and the median number of locations overall was 6, with 90% covering between 1 and 11 locations.

Speech & language therapy in language units/classes was almost always described as on-going and intensive, and SLTs worked in a variety of ways: joint delivery of direct speech & language therapy with teachers or other staff; individual and group therapy with pupils in the classroom; individual and group work with pupils withdrawn from the classroom; and a range of indirect therapy activities.

- *All 31 SLTs worked indirectly through one or more professionals and with parents.*
- *87% of the 31 SLTs reported direct work with pupils jointly with teachers or other staff. Joint working was most often carried out with groups of pupils in the classroom, with 71% of SLTs working in this way.*
- *13% reported that they delivered direct speech & language therapy always on their own, (one of these SLTs worked jointly in one unit/class but not in another).*

Teachers and language units/classes

The returns from 11 teachers in language units also recorded a similarly high level of joint working and other types of collaboration. All undertook joint planning with SLTs of speech & language therapy programmes and all but two of educational programmes.

BEST COPY AVAILABLE

Parents and language units

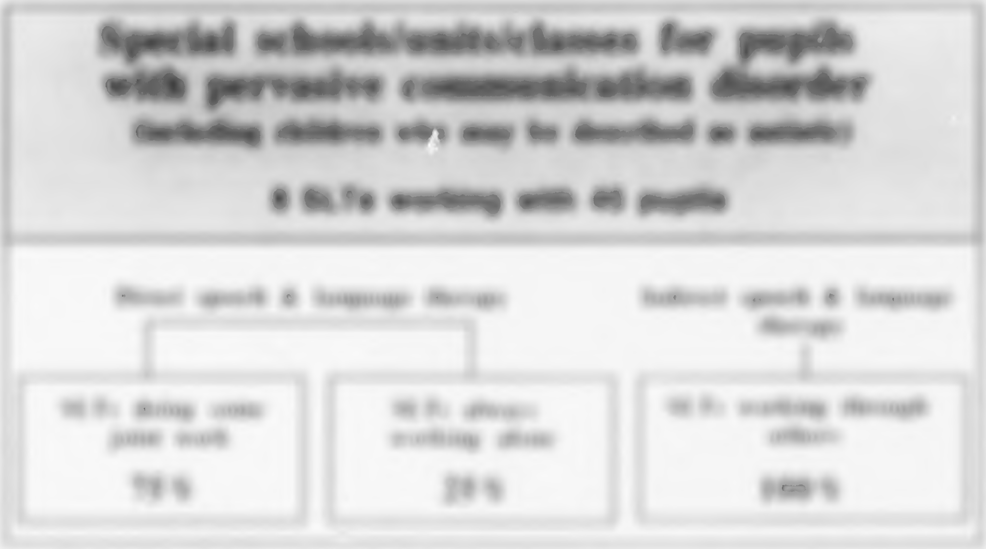
44 parents with children in language units/classes participated in the study. Most were very happy with their child's education and speech & language therapy, although some would have liked their children to have 'more' and a few mentioned the 'fight' they had had to get their children into the units. Several parents expressed concerns over the level of understanding of their child's difficulties in the wider world outside the unit/class:

> *"When mixing in his mainstream class, class teachers could be better briefed about his needs, his abilities."*

Also, several expressed fears around future placement:

> *"Once children reach High School age in Scotland there is no educational provision for [children with] language disorders."*

Special educational facilities for pupils with pervasive communication disorder (including autism)


Special schools/units/classes for pupils with pervasive communication disorder
(including children who may be described as autistic)
8 SLTs working with 45 pupils
Direct speech & language therapy
Indirect speech & language therapy
SLTs doing some joint work
75 %
SLTs always working alone
25 %
SLTs working through others
100 %

Speech & language therapists and special educational facilities for pupils with pervasive communication disorder

8 SLTs described how they worked in special educational facilities for pupils with pervasive communication disorders, who may also be described as autistic. These SLTs worked in 8 locations with 45 pupils. All worked with children/young people in at least one other location, typically 4 locations in total. They worked with between 3 and 11 pupils in this setting and had a median caseload of 42 children/young people across all the locations in which they worked.

The pattern of the SLTs' work in this type of educational facility is very similar to that of SLTs working in language units/classes.

- All 8 SLTs saw themselves as working indirectly through other professionals or support staff. In the main, these were classroom teachers and classroom assistants/nursery nurses.
- 75% (6) of the SLTs noted that they delivered direct speech & language therapy to pupils jointly with other staff.
- 25% (2) reported that they delivered direct speech & language therapy always on their own.

Teachers and special educational facilities for pupils with pervasive communication disorder

The 5 teachers in this type of location who returned questionnaires also reported a high level of collaboration, including joint working and joint planning with SLTs, both of speech & language therapy and educational programmes.

BEST COPY AVAILABLE

Parents and special educational facilities for pupils with pervasive communication disorder

Only 7 parents who returned questionnaires had children in special educational facilities for pupils with pervasive communication disorders. Responses from all of these parents suggest they were fairly happy with their children's education and speech & language therapy. Most mentioned that they thought the small classes and individual work were beneficial for their children.

> *"My daughter is in a small class, her teacher knows her well and understands her difficulties ... Because my daughter works in a group it improves not only her communication but also encourages social interaction ... In the 6 months since she has been in the unit at home I find it easier to understand my daughter and therefore there is less frustration on her part ... I feel I know how her therapy could be better, her class teacher gives encouragement in the class, it is part of her daily routine."*

All parents reported positively on their children's speech & language therapy, although one parent would have liked her child to see the SLT more than once a week. One parent particularly appreciated the SLT's knowledge of the child's difficulties.

Special schools/units/classes for pupils with hearing impairment

11 SLTs working with [illegible] pupils

Direct speech & language therapy

Indirect speech & language therapy

SLTs doing some joint work	SLTs always working alone	SLTs working through others
64%	36%	100%

Speech & language therapists and special educational facilities for pupils with hearing impairment

[illegible]

[illegible]

- [illegible]
- [illegible]
- [illegible]

[illegible]

[illegible]

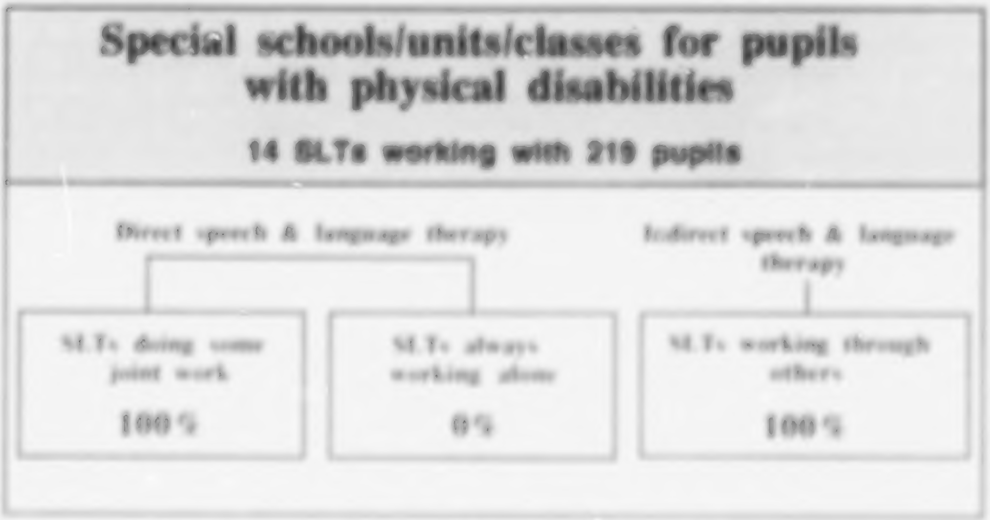
BEST COPY AVAILABLE

Teachers and special educational facilities for pupils with hearing impairment

24 teachers in schools, units and classes for pupils with HI returned questionnaires. They reported the same pattern of working as the SLTs: some joint working (5 teachers; 21%) but in the main collaborative practice centred around reporting and feedback between SLTs and teachers, planning together and observation of each other's work. Joint planning of speech & language therapy programmes was more frequent (59%) than joint planning of educational programmes (32%).

Parents and special educational facilities for pupils with hearing impairment

Only 3 parents with children at this type of location returned questionnaires. These parents were fairly happy with their children's education and speech & language therapy. However, one parent specifically felt his child would benefit from more individual work than the weekly, half-hour speech & language therapy session he received; this related to the only child who did not use signing amongst the 3 for whom questionnaires were returned. One of the other parents commented that more signing support was needed for hearing parents of deaf children. This was something that was also mentioned by the parents and some staff interviewed when the researchers visited special educational facilities for pupils with HI.



Special schools/units/classes for pupils with physical disabilities

14 SLTs working with 219 pupils

Direct speech & language therapy

Indirect speech & language therapy

SLTs doing some joint work

100 %

SLTs always working alone

0 %

SLTs working through others

100 %

Speech & language therapists and special educational facilities for pupils with physical disabilities

Questionnaire returns were received from 14 SLTs providing a service to 219 pupils in special educational facilities for pupils with physical disabilities; 5 of these SLTs were employed by the Scottish Council for Spastics. 13 of the 14 worked in only one special educational facility for pupils with physical disabilities. Nearly 40% (5) worked only in this type of setting, which is a much higher proportion than in any other educational setting so far. The median caseload of children/young people in special facilities for pupils with physical disabilities was 14, but 60% (9) of the 14 SLTs worked in other settings as well, so the majority had between 13 and 125 children/young people in total on their caseloads. The median overall caseload was 42. These SLTs worked with children/young people in up to 21 locations overall; the median was 4.

Responses would suggest high levels of collaboration of all types in these special educational facilities for pupils with physical disabilities:

- All 14 SLTs reported indirect work with a variety of other staff in all special educational facilities.
- All the SLTs noted that they worked jointly with other staff directly with pupils, both individually and in groups, in the classroom or elsewhere in the school, in all of the special educational facilities.

As would be expected in these schools, all the SLTs indicated that they collaborated with several different professionals and support staff. In almost all instances SLTs collaborated with class teachers and classroom auxiliaries/assistants, and in most they also collaborated with occupational therapists and physiotherapists. Half of the SLTs noted that pupils' speech & language therapy programmes were carried out by other staff when they were not present.

A majority of these SLTs also worked with another SLT. Our data suggests that this appears to be very unusual, even in the context of special educational facilities, where most SLTs do not have the opportunity to collaborate with another SLT.

Teachers and special educational facilities for pupils with physical disabilities

12 teachers in establishments for pupils with physical disabilities returned questionnaires but only 8 had pupils receiving speech & language therapy. Half of these teachers reported that they worked jointly with a SLT directly with pupils, and most reported a variety of other kinds of contacts with SLTs, including some joint planning of programmes. About a third would have liked more formal arrangements for contact with SLTs.

Parents and special educational facilities for pupils with physical disabilities

13 parents with children in special educational facilities for pupils with physical disabilities returned questionnaires. In general most were happy with elements of their children's education – in particular they commented positively on small classes and work in small groups. Nevertheless, a few parents felt their children's education could be better with more communication work and extra staff. One parent commented that appropriate provision closer to home would be preferable to residential school placement.

In terms of speech & language therapy, parents appreciated both individual and group work carried out with their children:

> "*The fact that my son gets both individual and group therapy is a good thing. He can be easily distracted by the other children or by other activities in the classroom, which is where the individual therapy in a separate room comes in, but he can also be motivated by watching what the other children are doing, which is where the group therapy benefits.*"

> "[At the moment, his speech & language therapy] *encourages my son to be as independent as possible and to make his own decisions … to use language (albeit limited) with Bliss board as backup. He has both individual and group sessions which is really encouraging him to initiate conversation as well as listening to others.* [My child's therapy could be better if there were] *more staff to enable more time for individual sessions.*"

As elsewhere, where parents felt that speech & language therapy was benefiting their children, they often wanted more. In addition, although most parents' responses would suggest that they were fairly satisfied with the speech & language therapy their children were receiving, some did have concerns. One parent mentioned the need for more resources for speech & language therapy generally, and another the need for more staff to enable more individual therapy to take place. One parent mentioned that their child's therapy had deteriorated when the child had moved from primary to secondary school.

Special educational facilities for pupils with visual impairment

Very few SLTs, teachers or parents returned questionnaires that related to pupils with visual impairment: only 3 SLTs, 9 teachers (5 of whom had pupils who were receiving speech & language therapy) and 1 parent. The numbers are too small to suggest any pattern.

- All 3 SLTs worked collaboratively to some extent with teachers/others; 4 of the 5 teachers with pupils receiving speech & language therapy reported collaboration with SLTs.
- 2 SLTs worked jointly with teachers/others in delivering direct speech & language therapy while 1 did not; 2 of the 5 teachers reported joint working.

Special educational facilities for pupils with emotional and behavioural difficulties

Only 4 SLTs working with 16 pupils gave information about their work in this type of educational setting. The numbers are too small to suggest any kind of pattern.

- All 4 SLTs worked collaboratively to some extent with teachers and others.
- 2 SLTs worked jointly with teachers/others in delivering direct speech & language therapy while 2 did not.

None of the parents who returned questionnaires had children who attended this type of special educational facility. Although 30 teachers in this type of educational setting participated in the research, only 2 of them had pupils who were receiving speech & language therapy.

How speech & language therapists work and collaborate: comparisons across different types of educational facility

In order to facilitate comparisons of speech & language therapy practice across the three types of mainstream and five types of special educational settings, Table 3.12 summarises some of the measures from each setting. As the working week of the vast majority of SLTs is spent in several locations, covering health, education and social work settings as well as clients' own homes, figures are given for:

(a) Numbers of SLTs working in each of the eight types of educational setting ('No. of SLTs'). It should be noted that, as many SLTs work in more than one type of setting, individual SLTs may be counted under more than one setting.

(b) Numbers of pupils receiving speech & language therapy by type of educational setting. ('No. of pupils seen by SLTs')

(c) Median numbers of, for example, mainstream nursery pupils, on the caseload of individual SLTs working in this educational setting. ('Median caseload: this type of setting')

(d) Median numbers of locations of all types (i.e. including health, education and social work settings and clients' own homes) covered by the SLTs given in column (a). ('Median no. of locations covered')

(e) Median numbers of under 19s, irrespective of the location in which they receive speech & language therapy, on the caseloads of the SLTs given in column (a). ('Median caseload: all types of location')

Table 3.12 **Caseloads of SLTs, numbers of locations in which SLTs work, and models of delivery of speech & language therapy for eight types of educational facility**

	(a)	(b)	(c)	(d)	(e)	Direct speech & language therapy		Indirect sp. & lang. therapy
	No. of SLTs	No. of pupils seen by SLTs	Median caseload this type of location	Median no. of locations covered	Median caseload all types of locations	SLTs work jointly with other staff	SLTs work always on their own	SLTs work through other staff
Mainstream settings								
Nursery	[illegible]	[illegible]	9	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Primary	[illegible]	[illegible]	20	9	61	[illegible]	[illegible]	[illegible]
Secondary	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Special educational settings								
Pupils with learning difficulties	[illegible]	[illegible]	19	7	52	[illegible]	[illegible]	[illegible]
Language units/classes	[illegible]	[illegible]	[illegible]	6	[illegible]	[illegible]	[illegible]	[illegible]
Pupils with pervasive communication disorder	8	[illegible]	[illegible]	6	[illegible]	[illegible]	[illegible]	100%
Pupils with hearing impairment	[illegible]	[illegible]	[illegible]	8	[illegible]	[illegible]	[illegible]	100%
Pupils with physical disabilities	[illegible]	[illegible]	[illegible]	8	[illegible]	100%	[illegible]	100%

If SLTs working in mainstream primary schools are compared with those working in special educational facilities for pupils with learning difficulties, it can be seen that:

(i) Median caseloads for these two locations are very similar, with 19 in facilities for pupils with learning difficulties and 20 in mainstream primary schools.[17]

(ii) SLTs working in facilities for pupils with learning difficulties have a somewhat lower overall caseload (all types of locations) of 52 compared to the 61 of SLTs working in mainstream primary schools.

(iii) SLTs working in facilities for pupils with learning difficulties worked in a median of 7 locations overall, slightly lower than the median of 9 for the SLTs working in mainstream primary schools.

---

[17] However, this statistic may need to be viewed in the context of a higher density of pupils receiving speech & language therapy in special, compared with mainstream, educational facilities. In mainstream schools, pupils receiving speech & language therapy will be spread over a larger number of classes and schools than in special educational facilities.

However, these differences are relatively modest and it is difficult to see how they alone might account for the much more dramatic differences in the extent to which SLTs are working jointly with education staff in these two types of setting. Not only are SLTs and teachers undertaking less joint work directly with pupils in mainstream primary schools, but, according to teachers, it would appear that they are also undertaking less joint planning. Table 3.14 is a comparison of the prevalence across different types of educational setting of these types of collaborative activity undertaken by teachers and SLTs, as reported by teachers.

Table 3.14 Teachers reports of collaborative work undertaken with SLTs

	Mainstream settings			Special educational settings for pupils with				
Joint work and joint planning	Nursery schools/classes	Primary schools	Secondary schools	Learning difficulties	Specific language disorders	Hearing impairment	Physical disabilities	Pervasive communication disorder schools
Teacher and SLT work together in the classroom with individuals or groups of pupils	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Teacher and SLT plan together educational programmes (or part of programmes)	[illegible]	[illegible]	[illegible]	33%	[illegible]	[illegible]	[illegible]	[illegible]
Teacher and SLT plan together speech & language therapy programmes (or part of programmes)	[illegible]	[illegible]	[illegible]	44%	[illegible]	[illegible]	[illegible]	[illegible]

Across all mainstream and many special educational settings, teachers reported a relatively low percentage of joint planning with SLTs. Only in language units/classes was joint planning the norm, both for speech & language therapy and educational programmes. Joint planning of programmes was reported by teachers in other special educational facilities but much less frequently. Joint planning more often involved speech & language therapy programmes than educational programmes (with the exception of special educational facilities for pupils with pervasive communication disorders). In special educational facilities for pupils with learning difficulties, only 44% of teachers with pupils in their class receiving speech & language therapy had collaborated with SLTs in the planning of speech & language therapy programmes, and only 33% in the planning of educational programmes, during the previous school term. While this is considerably higher than the 3-4% of mainstream primary teachers who had been involved in joint planning with SLTs, it is still a relatively low figure overall.

While the focus in the descriptions given in this chapter has been largely on 'joint working with pupils' as a gross measure of the prevalence of 'strong' collaborative practice, it may be argued that 'joint planning of programmes' is an equally valid measure of the relative strength of collaborative practice. Effective collaboration may take place without professionals physically working together with pupils, where there is a mutually agreed 'division of labour', but it is difficult to envisage effective collaboration without some degree of joint planning. However, even if 'joint planning of programmes' is adopted as a measure of the prevalence of collaborative practice, the figures in Table 3.14 indicate only a modest degree of collaboration between teachers and SLTs in the majority of schools.

Summary and discussion

Data from questionnaires returned by speech & language therapy managers and SLTs showed that, in Scotland, as at 31 March 1996:

- The number of SLTs in post had increased by around [illegible]% since 1990, due at least in part to the Secretary of State's (1991) Initiative.
- There were reported to be [illegible] SLTs working at least partly with children and young people.
- Provision of an 'on-site' speech & language therapy service to schools had increased, especially to mainstream nursery schools/classes and secondary schools, although the level of provision to secondary schools remained relatively low overall.
- Considerable numbers of educational facilities across all types were identified by speech & language therapy managers as 'requiring but not receiving' a service.
- [illegible]% of all under 18 clients were seen by SLTs in an educational setting.
- There were just under [illegible] children and young people within the speech & language therapy service, of whom [illegible]% were known to have a Record of Needs.
- A professional emphasis on early identification and intervention was reflected in the finding that [illegible]% of under 18 clients fell into the 0–4 year age band compared to [illegible]% in the 12–18 year age band.
- While a variety of factors affected SLTs' prioritisation of their caseloads, only [illegible]% of SLTs referred to a service policy or formal guidelines.

Drawing on data from survey results from SLTs, teachers and parents, patterns of work and collaboration were investigated across eight different types of educational facility. It is apparent that, even using very broad measures such as those employed in this study, there are considerable differences in the models of service provided by SLTs to pupils in different educational locations. The type of setting may facilitate or hinder a particular model of service delivery, but our data suggest that the type of establishment alone does not determine how speech & language therapy is provided. Across the range of educational locations, SLTs are working in a variety of ways, more and less collaboratively with teachers and other staff.

While there are differences in median caseloads and median locations covered by SLTs working in different types of educational facility, these seem relatively minor in comparison to the more dramatic variation in the prevalence of joint working between SLTs and other staff. While the vast majority of SLTs considered that they provided indirect speech & language therapy through other staff in all settings, working alone with pupils was much more prevalent in mainstream than in special educational settings.

Some of this variation may be explained by differences among schools in how many of their pupils have speech, language and communication difficulties, how much speech & language therapy time is allocated to those pupils, and therefore how much time the SLT spends in the school. Where a class teacher has a high proportion of pupils who are receiving speech & language therapy, it may be considerably easier for a collaborative partnership to evolve in the context of frequent and regular contact, even if only in an informal framework, between teacher and SLT. On the other hand, where a class teacher has only one pupil receiving speech & language therapy, and the SLT spends a very short time in the school, it may be extremely difficult for the SLT and teacher to achieve a satisfactory level of liaison.

Not surprisingly, where the ratio of SLT to pupils, and also the ratio of SLT to education staff, is very high, such as is the case in many educational facilities for pupils with physical disabilities or in language units/classes, the levels of all types of collaboration between SLTs and other staff are correspondingly high. Where an individual SLT has a remit which requires her to provide a service to pupils in several different schools, irrespective of the nature of the schools or their pupils, the practical difficulties involved in building up effective working relationships with many different teachers may appear almost insurmountable to the individuals involved.

Where a school has large numbers of pupils with Records of Needs, or speech & language therapy is being provided under an education contract, the allocation of speech & language therapy is more likely to be school-based, or at least partly school-based, rather than clinic-based. Where a special school, unit or class has a high proportion of pupils with a Record of Needs specifying speech & language therapy input, one or more SLTs may spend a considerable part of the week in the school, thereby enhancing the availability of opportunities for liaison with teaching staff.

Joint planning and joint working were found to be more prevalent in special educational facilities than in mainstream schools, although some evidence of these was also found in a few mainstream settings. However, the most prevalent model of speech & language therapy in mainstream schools was still a traditional one of individual withdrawal of a pupil from class, and reliance on collaboration with parents rather than teachers.

Possible factors influencing the working practices of SLTs include the number of pupils in the school on a SLT's caseload, the number of class teachers involved, the time available to spend in the school, and less tangible factors such as the level of understanding and support from teachers. Succeeding chapters will explore such factors further.

CHAPTER 4

Speech & language therapy in schools: case studies

Introduction

[illegible]

[illegible]

[illegible]

[illegible]

flexible working practices and the integration of speech & language therapy and educational programmes (CSLT, 1991).

Core principles of service delivery to mainstream schools

1. [illegible]

2. [illegible]

3. [illegible]

4. [illegible]

5. [illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

Case Study 6:
Innovative speech & language therapy practice in a mainstream primary school

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

The speech & language therapist's perspective

[illegible]

> [illegible]

[illegible]

- [illegible]

- [illegible]

- [illegible]

- [illegible]

- [illegible]

- [illegible]

> [illegible]

[illegible]

> [illegible]

[illegible]

[illegible]

The school's perspective

[illegible]

> [illegible]

[illegible]

[illegible]

[illegible]

[illegible]

- [illegible]
- [illegible]
- [illegible]
- [illegible]
- [illegible]

potentially remediable, difficulties) with the needs of the school, in providing help for a wider range of pupils. She had allowed the school to select pupils for some of her group work, and found that a majority of those selected were pupils who were already 'on her books'. She had negotiated with her line manager a system for dealing administratively with the group work (*"she (her manager) wouldn't be too happy if she thought I was spending a lot of time with children who were not really speech & language therapy cases"*)

- **Joint development of programmes** results in a feeling of joint ownership. The benefits of enhanced understanding are transmitted to a wider context.

- From the SLT's regular and ongoing **contact** with the teaching staff in this school, a clearer idea of the SLT's role had developed so the staff were more realistic about what could and could not be done; and they stopped expecting magic wands!

The priorities of the school staff and those of the SLT are not always the same but **differences are resolved through discussion and negotiation**, and because there is a **real sharing of responsibility** for the programmes they undertake, speech, language and communication is not seen as 'tacked on' to the curriculum but as part of it.

Differences in perspective

Our interviews pinpointed some interesting differences of opinion. Both AHT and SLT expressed the view that lack of parent back-up for many of the pupils in the school was a major issue. However, they showed less agreement on how this should be tackled. While the AHT argued that lack of parent back-up made it even more imperative for children's speech & language therapy to be provided in the school, the SLT was less enthusiastic about a wholesale move from a clinic-based to a school-based service. She felt strongly that, for some children, it was better for them to be seen in the clinic, where she had access to all her specialist equipment and materials, and where it was easier to maintain the collaborative links with parents which had been established for many children in their pre-school years. In her experience, although there were some parents who found it difficult to participate in therapy whatever it was provided, parents in general were more reluctant to join in therapy sessions if these were conducted in school. Where the teacher may have construed parents' reluctance to come into school as lack of commitment to, or interest in, the pupil's education/therapy, the SLT recognised the possibility that parents might feel they had no role to play in the pupil's therapy if this was provided in the school. She expressed a view that the school staff would agree with her about the need to maintain clinic-based services *"for children with specific problems"*, but this did not correspond with the views expressed by the teachers during their interviews. They viewed the clinic-based work with individual pupils as problematic, because *"the children who most need help are the ones least likely to attend regularly or at all."* The AHT would much prefer all speech & language therapy to be delivered in school. She recognised that access to appropriate accommodation would be essential for this to be feasible, but perhaps underestimated the professional isolation which this arrangement would entail for the SLT. The SLT did express a desire for some space of her own in the school, so that she did not have to transport all her materials back and forward all the time, but this was clearly not a priority for her.

Our interviews with teachers in a variety of schools suggested that, in general, teachers have little awareness of the nature and extent of collaboration between SLTs and parents in clinic-based therapy. Where children are placed in mainstream schools and collaboration with teachers is both difficult (because of time constraints) and unproductive (because teachers and SLTs are not on the same wavelength), it is hardly surprising that SLTs continue to rely on parental collaboration as they have done in the past. Very few SLTs appear willing to work in complete isolation, but where they do, this tends to be in mainstream schools (see Chapter 5).

From our interviews in a variety of schools, it seems that, when teachers talk about wanting the SLT in the school, many of them mean a model of withdrawal of individual pupils to a speech & language therapy clinic within the school, rather than a model which includes joint planning or the SLT working in the classroom. Is this because they have no experience of a SLT in the classroom, therefore they fail to see this as a possibility? The teaching staff from School A had experienced a SLT who demonstrated a variety of approaches to speech, language and communication programmes and who engaged the teaching staff in a variety of ways of working which included joint planning and joint working, individual and group work with pupils and skill-sharing techniques. It seems likely that positive experiences had shaped the attitudes of the school staff and influenced the extent to which they shared with the SLT the responsibility for speech, language and communication development in their pupils.

Case Study B:
A school-based initiative to improve pupils' speech, language and communication

The school, which we shall refer to as School B, was recommended to us by an adviser in special educational needs as an example of a school-based initiative in the area of pupils' speech, language and communication skills. This was a primary school with extra allocation of learning support because it was located in an area of high social deprivation. The initiative was instigated because of a consensus that many of the children coming into Primary 1 had 'impoverished language'. The idea was to start a group for pupils who were particularly 'behind' in language. The area learning support team would commit some teaching time to the group and the SLT who provided (clinic-based) speech & language therapy for some of the pupils in the school was asked for some advice.

The school asked parents for permission to administer a vocabulary test to all the children due to go into Primary 1. Those who scored at least one year behind their chronological age were targeted for group language work. The SLT was not directly involved in the group work. She had been involved in the planning of the initiative, and had given some help with ideas for group activities and in assessing children (although the school did the initial selection, and the SLT only provided a broader-based assessment of these selected pupils).

The SLT also agreed to follow up those pupils who appeared, from her assessment, to have more specific problems, and to re-test all the pupils who had been involved in the groups later in the school year, so that the school could assess whether the group work was having a measurable impact on the pupils' speech, language and communication. All the staff involved in the group work were enthusiastic about it and felt not only that the pupils were benefiting from it, but that the staff were also gaining insights which they were able to put to good use in their general teaching.

In this locality, the speech & language therapy service only provided a school-based service to some children/young people with a Record of Needs. Otherwise, SLTs here did an advisory visit to schools in their area at least once a year. The purpose was primarily to discuss with the head teacher and class teachers specific pupils who were receiving speech & language therapy (clinic-based). The SLT interviewed thought that these visits had raised teachers' awareness and that more referrals from teachers had resulted. (However, health visitors remained the main source of referrals.) SLTs promoted in-service training when they visited schools and some school-based training by SLTs for teachers had been organised.

The SLT was happy to act 'in a consultancy role' with the school in question, but noted that most of the children in the school's language groups 'did not have specific problems' (therefore, by implication, were not candidates for speech & language therapy). She thought it could be a good idea for her to be more involved in the school.

and also for her to give in-service training to the school. However, she said they had to remember that the speech & language therapy service was 'in the remediation business'.

The assistant head teacher said they found the planning meetings they had with the SLT useful but that they really needed more input. They would have liked more guidance, some advice on the likely progression for the pupils, more feedback on the difficulties of individual pupils, and, if possible, would have liked a 'profile' for each pupil with activities and targets. They made up some activities from what the SLT suggested at the beginning but they had difficulty knowing where to go from there. They would also have liked some guidance on any commercial resources available. However, the AHT admitted that they had learned a lot, although they felt very unsupported and felt that they did not have the necessary skills.

One of the class teachers said she would have liked more basic help from the SLT. Although the SLT's ideas were good, she needed to see the SLT put them into practice in order to be able to learn by example. She also mentioned needing to have more specific goals as well as specialist materials. She spoke of 'going in blind' and feeling inadequate. The results of the tests which the SLT had administered to the children needed more explication. The teachers recognised some of the reported difficulties but because they had not addressed speech and language difficulties systematically before, they did not know how to tackle them. This class teacher also expressed a need for someone to evaluate what she and her colleagues were doing and to give them critical feedback.

The head teacher felt that before the groups and the planning meetings with the SLT, they had believed in the 'magic wand syndrome' (i.e. the notion that access to speech & language therapy could make a pupil's difficulties magically disappear); she emphasised that they had not known previously what the SLT and the speech & language therapy service had to offer. She expressed concerns that, as it was provided within the context of the health centre, speech & language therapy was seen as 'medical'; this affected how she sought permission from parents to refer pupils for speech & language therapy. While she recognised that parents needed to know about their children's difficulties, she felt that parents would accept a referral more readily if it was seen as 'extra help in school'; speech & language therapy needed to be seen as part of education, not as a medical problem that could be 'fixed'. In addition, she expressed a desire for the SLT to come into the school instead of pupils going out to a clinic, where, in any case, they often failed to attend. She did not envisage the SLT working in the classroom; for her, improved access to speech & language therapy would result from changes to the location in which the service was delivered rather than to changed ways of working.

In School B, as in School A, we again see differences in outlook on what constitutes a speech, language or communication difficulty. The SLT felt constrained to work only with pupils who had a specific, and remediable problem, whereas the school felt it was their duty to provide for all pupils with low levels of speech, language or communication, irrespective of the nature or 'cause' of their poor achievement. A child who appeared to be relatively immature in all respects including language development would be an unlikely candidate for intervention as far as a SLT was concerned, especially compared to a child showing much more appreciable discrepancies between levels of functioning in different developmental areas. A teacher, on the other hand, might consider both of these children as 'underachievers' compared to the rest of the class and therefore in need of extra help. When the AHT in School A was asked which pupils should receive extra help, she responded that it did not matter why a pupil did not have the relevant skills; if the pupil did not have them, he or she needed help to acquire those skills. The SLT in School A had resolved this difference in outlook on selection of pupils for language work by including other pupils than those on her caseload in 'her' group work. However, not all managers of speech & language therapy services might agree with this strategy. On the other hand, since School A took up the group work and carried it forward both with the original group and with others, this might have provided a solution for another school whose SLT was more 'constrained' by her contract. In any case this is an area in which individual solutions need to be found, wherever SLTs are providing a school based service.

The lack of opportunity to observe the SLT working and to learn by example was felt to be a weakness by all the teaching staff involved in the group work in School B. In this school, in contrast to School A, the staff were not confident that they had either the knowledge or the skills they needed to make the group work effective. They had no doubt that the group work was needed but felt that they were to some extent 'working in the dark'. However, even this minimal sort of contact with a SLT had begun to change opinions about what a SLT could do and what skills she could share with teaching staff. School B was quite prepared to take the necessary responsibility for the group work and the area learning support team was prepared to allocate additional resources. However, perhaps the teachers needed just a little more contact, guidance and feedback to give them confidence in the importance of their role with pupils with speech, language and communication difficulties. The 'consultancy' model described above had failed to give them this.

Individual SLTs on their own cannot change a service based almost entirely on one-to-one withdrawal into one based on a broader, more collaborative framework. On the other hand, neither can one school bring this about, even with the commitment and allocation of its own resources, unless this is matched with adequate allocation of school based input from at least one SLT.

Summary

This chapter has presented two case studies to examine issues which appear to be important in the development and maintenance of collaborative partnerships between teachers and SLTs providing school-based services. Although there are various obstacles which make effective collaboration particularly difficult in mainstream schools (e.g. the limited amount of time which the SLT is able to spend in each school), these case studies indicate that collaboration in mainstream settings is nevertheless possible. The following were highlighted as some of the factors which are likely to contribute to successful collaboration:

- Good relationships and a shared understanding (e.g. about roles and priorities) between the SLT and individual members of the school staff
- Recognition of the importance of regular, ongoing liaison and appropriate organisation to ensure that the necessary time and opportunities are available
- Liaison between the SLT and a teacher who has an overview of pupils' general learning needs
- Shared knowledge and interests between SLTs and teachers (e.g. teachers having specialist knowledge of language development)
- Joint planning and development of programmes, resulting in a feeling of joint ownership
- Continuity of relevant staff
- SLTs' willingness to negotiate with their line managers in order to reconcile conflicts between the demands of their role and the needs of the school
- Opportunities for SLTs and teachers to observe each other working and to participate jointly in group work

These factors are closely intertwined with one another. Furthermore, it is clear that successful collaboration is dependent not only on the personal and professional qualities of individual SLTs and teachers, but also on the general philosophy and organisational structure of the speech & language therapy services and of the schools within which they work.

CHAPTER 5

Speech & language therapy provision: policy issues

Introduction

This chapter considers the policy issues highlighted in this study, drawing mainly on qualitative data from both questionnaires and interviews. The impact of the Secretary of State's (1991) Initiative on speech & language therapy services, and on recruitment and retention of SLTs, is examined. Various pressures on the speech & language therapy services are discussed. Records of Needs are considered from the perspectives of speech & language therapy managers, educational psychologists and parents. A number of themes emerged from our data, highlighting factors shaping the provision of speech & language therapy: gaps, inadequacies and pressure points. We discuss whether SLTs might be employed by education rather than health. Finally, we propose an educational analysis of speech & language therapy needs in terms of a multidimensional model.

Implementing the Secretary of State's (1991) Initiative

Interviews with individual speech & language therapy managers were helpful in clarifying exactly how the Initiative was implemented in practice. However, the one point made repeatedly by all those interviewed was that there were significant differences from area to area in both the management and the implementation of the new arrangements. While in some areas completely new posts were created for SLTs with specific responsibility for named pupils with Records of Needs, in other areas the change in funding arrangements for services, and the new contracts with education authorities, were used to influence generally the number of therapy sessions allocated to the paediatric service covering a particular geographical area and the schools within its catchment area. In particular, many special educational facilities benefited from an increase in their allocation of SLT sessions.

According to information provided by speech & language therapy managers through postal surveys, over 80 new SLT posts were created in Scotland in the course of implementation of the Initiative. In areas with recruitment difficulties, some of the new posts remained vacant (at least 9.1 WTE posts across Scotland as at 31 March 1993), although managers were able in some cases to increase the hours of part-time staff in order to fulfil the new education contracts. Particularly where more highly specified contracts with education had been made, the new 'special needs' posts, which in many cases carried higher salary grades than community or pre-school paediatric posts, were filled by experienced SLTs already working in the locality. One result of this transfer of experienced SLTs to the education sector was the corresponding loss of skill, expertise and experience from the community paediatric sector. The effect of this on the service available to pre-school children is a worry for the future for many managers.

It was extremely time-consuming to complete and cost new contracts, time which would otherwise have been available for clinical work. Different types of procedure evolved for reporting back about the service provided during the previous contractual year. Some speech & language therapy services described every activity including direct and indirect contacts with pupils, liaison time with education staff, time spent in meetings, report writing, programme planning and travel to schools, so that when the time came to renew the contract, precise and detailed data were available on which to base future planning and decisions.

Partly because of the specifications of the service arising from contracts, and also in line with the move towards more explicit procedures for prioritisation of clients for speech & language therapy, there is now a general trend to provide less therapy for children/young people with mild speech, language or communication disorders and to target input to children/young people with more significant problems. For some SLTs at least, this has been viewed as extremely helpful in dealing with large caseloads.

The Initiative arrived at a time when the profession had already begun to question and re-evaluate its role in the provision of services to children/young people in education. Both 'Communicating Quality' (CSLT, 1991) and a burgeoning literature advocated the case for collaborative practice in educational settings. However, as we have shown in Chapter 3, the traditional style of withdrawal-based therapy for many pupils in mainstream schools has not yet succumbed to a more collaborative philosophy.

There are worries within the speech & language therapy profession that it will not be possible to maintain the current high level of service to education, if no additional funding for the purchase of services is made available to local authorities in future years. According to information from speech & language therapy managers, it is not the case that all speech & language therapy for children and young people with Records of Needs is at present provided through education contracts. One manager [illegible] calculated that there was a 4% annual uplift in the funding due to salary increments, inflation and so on, but no clear formula or mechanism for taking this into account. In addition, each year, more and more children/young people are referred and have speech & language therapy specified in their Record of Needs, but fewer are discharged. In the past, speech & language therapy input would often be dropped as a pupil moved into secondary education – now, with pupils with Records of Needs, the continuing need for speech & language therapy support for certain secondary pupils with speech, language and communication difficulties will be highlighted. In the light of these matters, it would seem important that speech & language therapy managers have input to the discussions between COSLA and the Scottish Office on the annual review of the financial needs of local authorities.

Managers' views on contracts with the education authorities need to be considered within the broader context of other funding arrangements. With the advent of the new unitary authorities and further developments in the purchaser/provider arrangements in the health service in Scotland, such as the possible introduction of 'local pay bargaining', and the development of GP fundholding, managers expect to contend with yet more changes in funding arrangements for speech & language therapy. In the view of speech & language therapy managers, all of these factors will combine to create great pressures on the system in the near future.

In summary, the Initiative has been viewed as beneficial in that it has brought about changes which have enhanced the speech & language therapy service, both through increases in staffing and a consequent [illegible] and, in some cases, restructuring of the services to children/young people in educational settings. For some speech & language therapy managers and other personnel involved in child health services, the loss of clinical time to the 'paperwork' of contracting has been used to support their argument that additional funding should simply have been channelled through existing speech & language therapy departments, rather than going to education for the purchase of service contracts. Whether, if that had happened, the undoubtedly beneficial aspects of service review and restructuring would still have resulted, is a moot point.

Recruitment and retention of speech & language therapists

Adding to other pressures on the speech & language therapy service, recruitment and retention of suitably qualified and experienced SLTs is a chronic worry for managers, especially in outlying rural areas. There is always a number of unfilled posts for SLTs in Scotland. One survey of SLT managers revealed that at March 1996, unfilled posts in

[illegible]

[illegible]

[illegible]

Integration into mainstream schools of pupils with special educational needs

[illegible]

school to school and in finding ways to collaborate effectively with a large number of class teachers, support teachers and classroom assistants/auxiliaries.

The intensive workload of working with pupils with a Record of Needs in mainstream schools was evident in some of the questionnaire returns from individual SLTs. Having described the positive aspects of working closely with parents, one SLT went on to describe her work in schools:

> "I am most unhappy with my work with children with "special needs" in my [illegible] [illegible] [illegible] [illegible] [illegible]. [illegible]
>
> (a) teachers want you to take the child out for therapy or to provide a [illegible] programme for them to work through with the child [illegible]
>
> (b) generally teachers are very willing to give up their own time to discuss children [illegible]
>
> However, this SLT felt she could work more effectively with parents who are [illegible] about language disorders:
>
> (c) I have tried to work through [illegible]
>
> (d) I would like to work with small groups on activities [illegible]
>
> [illegible]

SLTs have been stretched over recent years by increasing demands from [illegible]

A number of other difficulties in working in mainstream schools [illegible] both managers and SLTs.

- **Accommodation**: In mainstream schools it often [illegible]

[illegible]

- **Access to appropriate equipment** [illegible]

- **Collaboration with parents** [illegible]

Issues relating to Records of Needs

[illegible]

Speech & language therapy managers and Records of Needs

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

> [illegible]

> [illegible]

> [illegible]

[illegible]

> [illegible]

> [illegible]

> [illegible]

Speech & language therapy for pre-school and other children [illegible]

[illegible]

[illegible]

> [illegible]

[illegible]

[illegible]

[illegible]

[illegible]

Speech & language therapy in mainstream secondary schools

[illegible]

[illegible]

Speech & language therapy for hearing-impaired pupils

[illegible]

[illegible]

[illegible]

[illegible]

Other challenges for speech & language therapy services

[illegible]

- [illegible]
- [illegible]

Should speech & language therapists be employed by education rather than health?

[illegible]

to directors of education specifically permitted education authorities, in cases where the relevant health board for the area was unable to assure services sufficient to allow the education authority to fulfil its statutory obligations, to employ SLTs directly; to "acquire the services of other speech therapists, on a private basis" ; and/or to draw up contracts with health boards other than that responsible for the area of the education authority seeking speech & language therapy support (SOED, 1992). The current study has found no evidence of an education authority in Scotland having to date taken up any of these options.

The exception, in Scotland, is the case of schools in the grant aided sector, where SLTs are employed directly either by schools or by the voluntary agencies responsible for running the schools. For example, the Scottish Council for Spastics employs a number of SLTs in its schools. In many ways this works well, at least partly because working with children/young people with cerebral palsy is a very specialised area. This means that these SLTs have more in common with members of other professions who also specialise in cerebral palsy than with members of their own profession who do not. Nonetheless, these SLTs describe some drawbacks, of which the greatest is undoubtedly a degree of isolation from their professional peers.

Educational psychologists surveyed by the current project were the only professional group to whom this question (of whether SLTs should be employed by education) was formally put. Since so few psychologists responded to the survey (see Chapter 2 for details), the sample was not representative. Those in favour envisaged a major potential advantage as being a more co-ordinated service, with professionals' roles and responsibilities clearer to parents. A few respondents saw an advantage in the negative sense that it would avoid the need for all the expensive time and work currently swallowed up by 'paperwork' – the regular process of drawing up contracts between health and education authorities.

Informally, a multidisciplinary group of around 40 staff working in Language Units and related special facilities (SLUM – Scottish Language Units Meetings) were canvassed for their views. While the idea of qualifying for the shorter working hours and longer holidays of teachers was superficially attractive to the SLTs present[17], they also felt there would be disadvantages in being isolated from their own profession, in being the only SLT in a school. For the teachers present, an advantage might be that SLTs "wouldn't go off to meetings all the time" and that they would be in school all the time. This, however, would be true in only a very few schools, as only a small minority of SLTs are currently working full time in any one school.

Head teachers, interviewed during visits to schools, agreed with the SLUM teachers that SLTs might be out of the school less 'at meetings' if they were employed by education authorities. One head teacher offered the view:

> *"There would be advantages in SLTs being employed by education, if they could be prevented from having holidays in term time and there could be some control over absences at conferences and meetings .... I can't see any disadvantages."*

Only one or two head teachers mentioned what would be lost to the *pupils*, if SLTs worked teachers' hours. One head teacher said that he would prefer the SLT who worked in his school to be employed by education, contracted to work the same hours as teaching staff and not allowed to take holidays in term-time, provided that the SLT had the professional support she needed. This head teacher did recognise, however, that the SLT did a lot of work outwith the school timetable, in home visits after school and work during school holidays, and that this would be lost to families if she worked school hours.

---

[17] An assumption is being made here that, if employed by education, SLTs would have similar terms and conditions as teachers. However, this need not necessarily be the case. Educational psychologists are a case in point.

There are other arguments in favour of employment of SLTs by education, and these include the following:

a) For SLTs working in educational settings, some harmonisation of priorities with those of other education staff would ensue and achievement of a shared "world view" with teachers may be more easily attained.

b) SLTs would have easier access to educational information.

c) Direct lines of accountability for SLTs within education would make SLTs less likely to find themselves "serving different masters" and having to reconcile conflicting demands.

c) Savings in administrative effort might be achieved if the contracting process between education and health was no longer required (although education would have to bear "new" costs involved in administering the SLT service).

d) A move from health to education might be the only way of securing an adequate service if SLT departments, as part of NHS trusts, become unable to provide the service as required by education authorities.

However, many education staff and SLTs disagreed with the idea of SLTs being employed by education authorities. The main arguments against the employment of SLTs by education authorities include the following points:

a) the current arrangements work satisfactorily, by and large.

> *"The necessary contractual arrangements have been smoothly negotiated from their inception through very harmonious collaboration between education and health and there is regular review of the adequacy of provision and staffing. We would see no benefit in changing to a situation where therapists were directly employed by education."*
>
> (Principal educational psychologist)

b) In order to fulfil their professional obligations, from time to time, SLTs have to make themselves available to attend medical or interdisciplinary case-conferences, meetings etc. Similarly, in order to maintain and develop their special professional competencies SLTs need to have access to in-service training, different from that of their teacher colleagues, and to meetings with speech & language therapy peers.

c) SLTs require clear management structures and have the right to a proper career path. It is unclear who, in an educational setting, would be in a position to manage individual SLTs working in schools. It is likely that it would be very difficult to recruit good SLTs to work in isolation, managed perhaps by head teachers with no SLT expertise.

d) Alterations might have to be made to the conditions of service of SLTs and/or of teachers, whose working conditions are currently very different. If SLTs were brought into line with teachers on "school" conditions of service, the special benefits of home visits and summer schools, would all be lost to schools and parents. However, SLTs employed by education would not necessarily have the same conditions of service as teachers.

e) The effect of a shift in employment base from health to education might be seen to imply negative repercussions for the service to pre-school children and those in health service locations, such as children/young people in hospital. However, there is a positive precedent to be found in the role of, for example, pre-school home visiting teachers, or teachers working in children's hospitals.

One educational psychologist summed up a "general" view:

> *"I am happy with the concept of service provided by the Health Board – the need is for more quantity, not a change in employment base"*

In summary, there appear to be both advantages and disadvantages in SLTs being employed directly by schools or education authorities. Under prevailing arrangements, many of the issues mentioned above could be dealt with at the level of contracts between education authorities and speech & language therapy providers, or at the level of agreements between individual SLTs and schools. Overall, it would seem that the issues which people perceive as important have more to do with terms and conditions of employment than with the employer as such.

An educational analysis of speech & language therapy needs

In earlier sections of this chapter, a number of problems have been highlighted in relation to the provision of speech & language therapy to pupils with special educational needs. Parents are concerned because Records of Needs often fail to provide clear specification of the nature or of the amount of the speech & language therapy provision which their child should receive. At the same time, speech & language therapy managers are experiencing difficulties in meeting the demands on their services from children/young people with Records of Needs without compromising other important areas of service provision. Both of these problems may stem (at least in part) from the lack of a framework for assessing children/young people's speech & language therapy needs which is shared by education professionals and SLTs and which facilitates the specification of different levels of need. At present, two assessment frameworks tend to be juxtaposed. In assessing children/young people's therapy needs, many SLTs are still heavily influenced by a medical model in which disorders are diagnosed. In contrast, the process of drawing up Records of Needs is based on an educational concept of need.

A possible way forward lies in developing a common framework in which speech & language therapy needs are specified in a way which makes clear how these needs could be met within an educational context and how they relate to other aspects of the pupil's educational needs. In this section, we propose a possible common framework, based on a model developed in a recent study of the criteria for opening Records of Needs (Thomson, Stewart & Ward, 1995). On the basis of their findings, Thomson et al concluded that the concept of special educational need is multidimensional and requires consideration of six discrete aspects of educational support, relating to:

- The physical environment
- The curriculum and how it is delivered
- The level of child/pupil support required
- The level of specialised resources, facilities and technologies required
- The level of specialised support agent(s) involved
- The mode of communication

For each of these dimensions, the degree of needs might be classified at any of four levels (see Figures 5a to 5d). Using this model, it is suggested that if a pupil's needs fall into Level 1, there is no basis for considering a Record of Needs, as the level of support needed is within the minimum resourcing available in all schools. Long term needs at any other level, on any of the six dimensions, might indicate (depending on other factors such as the level of resources normally available in the area) that opening a

Record of Needs would be in the best interests of the child/pupil. Although the model was originally designed to apply to a "one-off" decision about opening a Record of Needs, rather than to ongoing decisions by teachers and SLTs, we consider that the model might at least provide a useful starting point for communication between teachers and SLTs regarding the type and amount of support which would be most appropriate to a particular pupil's needs.

It is interesting to consider the extent to which the model is compatible with the way the speech & language therapy profession would be likely to classify levels of need. We will now explore this issue in relation to Levels I to IV along the strand 'the level of specialised support agent(s) required'. According to the model, only pupils at Levels of Need III and IV might be likely to receive ongoing direct speech & language therapy, and one-to-one therapy would probably be confined to pupils at Level IV. Pupils at Levels I & II would receive only speech & language therapy advice and programmes carried out by teachers and other staff.

Figure 5a Level I Special Educational Needs

Needs relating to	Level I Needs
The physical environment	The ordinary nursery/class/school is appropriate
The curriculum and how it is delivered	Ordinary curriculum with minor features of differentiation in relation to '5–14' guidelines, such as specific objectives for reading, listening, etc Alternative methods of presentation within the group
The level of pupil support required	Levels of pupil support/contact in individual/group settings which are normally available, with short periods with the classroom aide in small groups
The level of specialised resources, facilities and technologies required	Ordinary available resources, facilities and/or technology shared with groups of pupils on a time-limited basis, e.g. word processors/personal computers
The level of specialised support agent(s) involvement	Needs identified and monitored by class teacher and within-school support staff, e.g. Learning Support in mainstream setting. Advice only from other external agent(s), e.g. Regional Authority Psychological Service, speech & language therapy, behaviour support, service for the sensory impaired etc
Mode of communication	Ordinary oral/aural and written with appropriate support from relevant aids

(Thomson, Stewart & Ward, 1995: Figure 9)

SLTs would see Level I as a need for assessment, diagnosis and possibly a therapy category of 'review', for some pupils. They would certainly expect to liaise with teachers and other staff over pupils taken on to the speech & language therapy caseload in this category. However, it is difficult, within the present NHS Trust conditions of employment for SLTs to justify time spent on giving 'advice' to teachers in regard to other pupils who are not 'officially' on the SLT's caseload. And yet, many teachers we interviewed identified a need for just such advice from a specialist.

In this category, we might also include pupils with, for example, pronunciation problems that are being treated in a clinic setting with parent collaboration. These may be pupils who are on the last lap of therapy which was started in the pre-school years; their needs are likely to be short-term, and they are less likely to be at risk of literacy problems than pupils with more general language problems (Bishop & Adams, 1990). Paradoxically in terms of this model, although the pupil support needs in school are low, the input from speech & language therapy may be relatively high (but short-term).

Figure 5b Level II Special Educational Needs

Needs relating to	**Level II Needs**
The physical environment	The child/pupil's needs are such that some special features are required in the nursery, class or school accommodation. For example, access to a resource base may be required for the delivery of structured programmes etc. for some of the time. The child may require ramps and other aids.
The curriculum and how it is delivered	Significant differentiation is needed in **one** or some areas of the '5-14' curriculum requiring structured and clearly targeted programmes in learning and/or behaviour which are subject to termly review.
The level of child/pupil support required	Direct individual support by Learning Support staff in small group. Use of scribe/reader. Short-term behaviour support to avoid causing stress to self/others.
The level of specialised resources, facilities and technologies required	Ordinarily available resources, facilities and/or technology required by the child/pupil individually on a time-limited basis, e.g. word processors/ personal computers.
The level of specialised support agent(s) involvement	Agreed and monitored support and advice from agent(s) cited in Level I, with clear objectives delivered by teacher and support staff deployed to support/teach child/pupil.
Mode of communication	Ordinary oral/aural and written with appropriate support from relevant aids.

(Thomson, Stewart & Ward, 1995: Figure 9)

At this level of need, SLTs would ordinarily assess, diagnose and create a carefully personalised programme of work which could be delivered by the teacher and other education staff. This would be considered 'indirect therapy' and would require the agreement and active co-operation of all staff concerned. This inevitably begs the question as to whether the resources of education staff are adequate to enable this to be done. In special schools and units, staff are more likely to be sufficiently numerous and experienced to carry out such work effectively. In mainstream, particularly at secondary level, this is not the case. There might be a case to be made for the involvement of a support teacher or an additional classroom assistant[18] (possibly one with a partly dedicated function for speech & language work), but it would be difficult for the speech & language therapy service to do this – it would need to come from the head teacher.

This level of the model could cause problems for SLTs where expected backup from education staff cannot be provided, and because of the training needs that arise. In practice, the SLT may need to be present to give ongoing support to other staff. SLTs may have to use an approach which includes some direct therapy observed and later consolidated by education staff. Well-targeted training conducted by SLTs can be very productive at this level.

In addition, our survey of SLTs revealed evidence that some SLTs working in an educational setting felt inadequately skilled in creating programmes for education staff, (for example, see the quote from one SLT earlier in this Chapter on page 76). It may be that this phenomenon is 'transitional' in that programmes which are sensitive to the educational context have only been expected of SLTs in recent times. We may hypothesise that such skills can be acquired relatively quickly by experienced SLTs once the situation demands it. However, there may be a need to incorporate more explicit attention to the development of this expertise in newly qualified and student SLTs and those who have had little or no experience of creating programmes which take account of the educational context.

---

[18] Different employing education authorities use different terms for this role. Amongst the names we came across are education or classroom auxiliary/aide/assistant/helper.

Figure 5c Level III Special Educational Needs

Needs relating to	Level III Needs
The physical environment	A specialist facility may be required, e.g. a resource base/unit within a mainstream setting, for a substantial portion of the child/pupil's time in nursery, primary or secondary school
The curriculum and how it is delivered	Very substantial and specialised differentiation is needed in a wide area of the '5-14' curriculum such as requires weekly review and consultation with agent(s) external to the school on an individualised teaching plan
The level of child/pupil support required	Enhanced level of individual child/pupil/aide contact required for some of the time, e.g. primary care needs (soiling, catheterisation etc.), behaviour support
The level of specialised resources, facilities and technologies required	Highly specialised resources, facilities or technology not normally available and deployed/designed for the child/pupil's specific use on a time-limited basis
The level of specialised support agent(s) involvement	Agreed, monitored and delivered support on a regular basis to small groups of children/pupils by specialist agent(s), over and above learning support, and engaging one or all of external agent(s) cited in Level I
Mode of communication	Highly specialised methods are required by the child/pupil, e.g. sign language, Braille etc

(Thomson, Stewart & Ward, 1995: Figure 9)

In speech & language therapy terms, Level III needs would imply assessment, diagnosis, creation of a programme and the addition of 'direct therapy' input. The difference here is that SLTs might well expect that education staff would *also* continue a programme of speech and language work when the SLTs were not present. In other words, indirect therapy would be used to complement and reinforce direct therapy. Again, the role of a support teacher or specialised classroom assistant could be important to ensure that indirect therapy is carried through. As in Level II, the availability of, and access to, ongoing staff training for the teachers and support staff involved would be a critical factor in the success of such programmes. Parents may feel that their child is being 'short-changed' if s/he does not have regular one-to-one sessions with the SLT, so access to good information and communication about the pupil's educational and therapeutic programmes, as well as more direct involvement where appropriate, would be particularly important where 'indirect therapy' programmes form an important part of a pupil's individual educational programme.

A SLT would probably prefer not to be tied to 'small group work', as specified in the model, but to have the autonomy to decide what is in the best interests of the communication impaired pupil(s) and what is practical. A pupil's speech & language therapy needs may be so specific that it may be impossible to put together a group with similar enough needs. The SLT might choose to deliver therapy in a pair or small group setting but might equally well feel that an individual pupil's needs were so specific that they required an element of one-to-one therapy at times. For example, there may well be only one pupil in a school learning to use an electronic augmentative communication system. The relevant input might be delivered within the classroom or on a withdrawal basis. The SLT would also wish to be able to use her professional judgement as to the type of therapy indicated. For example, rather than working one-to-one with a child, she may choose to work alongside the pupil in class, simplifying the teacher's language, supplying vocabulary and structuring sentence-building in a natural communication environment, instead of in an 'artificial' therapy situation.

Figure 5d Level IV Special Educational Needs

Needs relating to	Level IV Needs
The physical environment	A highly specialised environment, e.g. a special unit/school or nursery, is required for all the time the child/pupil is in the setting dealing with a combination of profound sensory loss, physical disability and/or disruptive behaviour
The curriculum and how it is delivered	The curriculum which the child follows is radically different from that provided in the mainstream in that it requires daily review and consultation with agent(s) external to the school in order to establish the pre-requisites for learning, e.g. cognitive, sensory development
The level of child/pupil support required	Child/pupil requires enhanced level of teacher and/or aide contact continuously. Extended primary care needs, continuous behaviour support, longer term life plan of total care needs
The level of specialised resources, facilities and technologies required	Highly specialised resources, facilities or technology not normally available and deployed/designed for the child/pupil's specific use on a continuous basis
The level of specialised support agent(s) involvement	Agreed, monitored and delivered support on an intensive basis on an individualised basis in a specialised setting, e.g. special unit, base or school, by specialist agent(s) as cited in Level I
Mode of communication	Highly specialised methods are required by the child/pupil, e.g. sign language, Braille etc

(Thomson, Stewart & Ward, 1995: Figure 9)

Speech & language therapy would be likely to correspond, in the main, to the educational pattern in the model at this level of needs. Therapy might be delivered individually, in pairs, groups, or classes, and would employ a mixture of direct and indirect methods. Therapy programmes are likely to be maximally integrated with pupils' individually differentiated curricula, and may be delivered by a multi-professional team. This level implies that there is a significant need for speech & language therapy input, and suggests that SLTs are on-site for a high proportion of the school week. The 'non-client contact' demands upon SLTs will be high. Staff throughout the school or unit will present significant training and support needs. Additional resources of specialised classroom/speech & language therapy assistants and volunteers may be necessary. There will be heavy demands upon SLT time for the preparation of special programmes and materials. Specialised technology may be used, requiring additional resources of time, training and support. In the light of these demands, SLTs' caseloads will necessarily be small.

Using the model in this way highlights a paradox. The less individual support that is available for a pupil generally in school, the greater may be the need for speech & language therapy input because there is less *other* support available. For example, in mainstream schools, SLTs might hope to work at the level of 'indirect therapy' with a pupil whose communication problems are not too severe. However, she may be unable to do this where there are no education staff with enough time or expertise to carry it out. In contrast, where a pupil is in a special school, or has an enhanced level of support, support for indirect therapy is likely to be much greater. In consequence, direct therapy input may be reduced, even when a pupil's needs are more extreme. This may look very puzzling to teachers and parents.

Summary and conclusions

The study has collected evidence from a variety of sources that the Secretary of State's (1991) Initiative has been successful in providing education authorities with the means to fulfil their obligations regarding the provision of speech & language therapy to pupils with a Record of Needs. The education contracts which resulted from the Initiative, together with the funding which primed the new system, not only led to the creation of over 80 new SLT posts throughout Scotland but also led to a (varying) degree of reorganisation of speech & language therapy services to pupils in schools. There appears to be agreement in all quarters that the Initiative has led to a general enhancement of the speech & language therapy service to pupils with special educational needs. However, it would appear that these improvements have not been achieved without cost.

The chapter reviews problems indicated by speech & language therapy managers in the recruitment and retention of suitably qualified and experienced SLTs. Recruitment of SLTs to work with children/young people can be particularly difficult, since such work tends to be perceived as having less prestige than work with adults. Future updates of the speech & language therapy professional standards and guidelines might consider recognising 'working in schools with pupils with special educational needs' as a professional specialism in its own right.

There are pressures on speech & language therapy services from many different areas, and managers reported difficulties in reconciling all the demands on their service. In the past, managers were sufficiently autonomous to allow them to do their own prioritisation, in the light of guidelines arising from within their own profession. Records of Needs and contracting have upset this process and new mechanisms need to be developed to ensure a fair division of what remains a relatively scarce resource. An attempt was made to account for the somewhat paradoxical view expressed by speech & language therapy managers that education contracts were compromising services to other client groups, in particular pre-school and other children without Records of Needs.

A variety of views were expressed regarding the advantages and disadvantages which might result if SLTs were employed by education rather than by health. The different employment conditions of teachers and SLTs sometimes appear to be a source of misunderstanding and conflict. There is a need for both groups of professionals (and their employers) to be aware of the complexities of each other's roles and to be willing to modify their own expectations and working practices.

In concluding this chapter, it was proposed that effective collaboration amongst professionals requires the development of a common framework for assessing pupils' speech & language therapy needs, for recognising the differing levels of need and for negotiating how these needs can best be met within an educational context. A first step towards the development of such a framework was made by exploring one possible model for an educational analysis of speech & language therapy needs.

CHAPTER 6

What makes for effective collaboration?

This chapter draws on data from a variety of sources: the series of postal surveys and the interviews carried out in the course of this project, and the literature and research findings of others. Data are interpreted to discern indications as to how effective collaboration can best be achieved. The discussion of material in this chapter may illuminate how SLTs, teachers and parents can work together to best serve the interests of pupils with speech, language and communication difficulties.

What is 'effectiveness' in speech & language therapy terms?

The speech & language therapy profession is currently deeply concerned with quality assurance and the development of outcome measures. It is beyond the scope of this report to discuss in detail issues of the efficacy of intervention and the different aspects of clinical audit and service accreditation[19]. However, speech & language therapy professional guidelines on audit relate to the culture of the NHS: the individual 'patient', measuring the 'quality of care', or the outcomes of 'episodes of care'. Current guidelines ignore the culture of schools and the perspective of access to the curriculum for pupils with special educational needs.

In order to address the effectiveness of speech & language therapy within education, should we consider:

- The delivery of speech & language therapy to pupils with special educational needs

  or

- The delivery of education, with the help of the SLT, to pupils who have speech, language and communication problems as part of their special educational needs?

In terms of the needs of the 'whole child', we believe it must be the latter.

One model of measuring effectiveness (or 'outcomes' in NHS terms) is that of 'consumer satisfaction'. There are a various parties involved in speech & language therapy services:

- **Consumers**: the pupils with speech, language and communication difficulties, their parents and family, and perhaps the class teacher
- **Customers**: the purchasers of speech & language therapy services: for some recorded pupils, education authorities contracting with speech & language therapy managers for services to schools; for most pupils, health boards
- **Stake holders**: NHS employers, managers and colleagues from the speech & language therapy profession, professional colleagues from other disciplines and all others involved with pupils with speech, language and communication difficulties

---

[19] The reader may wish to refer to the recently published guidelines, 'Audit: a manual for speech & language therapists' (CSLT, 1993).

This serves to highlight the difficulty of the task facing SLTs, who somehow have to satisfy all of these diverse individuals and agencies. This diversity is recognised by the RCSLT, which as well as laying out the professional standards of the speech & language therapy profession itself, specifically recommends the implementation of multidisciplinary audit systems where possible, "particularly in situations where there is potential for joint planning and record keeping" (CSLT, 1991: p. 251).

What do parents think about speech & language therapy?

In our survey of 520 Scottish parents, many made positive comments about their child's speech & language therapy:

> *"I don't think she could get better [speech & language therapy]"*

Many parents made particular reference to the good relationship their child had with their SLT:

> *"Child gets on very well with speech therapist which motivates her to try hard, thus gaining confidence … couldn't see therapy being any better."*

A number of parents also commented positively upon the value to their child of working with the SLT in small groups, showing that parents do not necessarily *just* want one-to-one attention for their child, although many did express a liking for one-to-one therapy, and said they would like more.

When asked, "In what ways could your child's speech & language therapy be better?", most answered that they would simply like more of it. They tended to want more frequent sessions rather than qualitative changes to the therapy. For parents, as for teachers, a major issue was one of ***time***:

> *"… quality excellent – just more of it would be good."*

However, parents were not always happy with the type of service their child was getting. Many wanted more individual help for their child, while others wanted more group work or therapy which was more integrated into the daily classroom routine. A few parents wanted more specialist help for their child, such as a parent whose child had previously received therapy from a SLT specialising in hearing impairment. A number of parents complained about the long distances their child had to travel to receive therapy or to attend an appropriate school. The following quote is a typical example:

> *"The therapy could be much better if the service was local and not a forty mile round trip."*

Continuity of speech & language therapy had been a major problem for some families. For example, several parents noted the need for therapy to continue through school holidays. Others were concerned about how staff changes, and lack of cover when a SLT was absent, affected their child; one child had seen six SLTs in nine years. Several parents would prefer to be more involved in, or more informed about, their child's speech & language therapy. Very few parents criticised the *content* of their child's therapy. However, in the case of those parents who did, they appeared to be looking for a service which was more forward-looking and innovative, such as in the following:

> *"The therapists have a good rapport with my child … I'm sure he gets daily or weekly therapy, but a lot more communication with us [the parents] as to what he does get would help us immensely. The therapist seems too set in her ways – i.e. new innovations seem to be viewed with scepticism."*

In one or two cases, the parents and the SLT were reported to have different goals and perspectives, and this appeared to be at the root of the parents' lack of satisfaction with the therapy programme:

> *"I feel he isn't getting much that I'm not already doing at home, and in fact the therapist often is trying to do things he could do a long time ago [therapy needs to be] more geared to stretching him as he is now ... she consistently underestimates his capabilities and its more a case of me suggesting things to her! But now he's starting on Makaton*[20] *this may change."*

From this study, another measure which may relate to parental satisfaction is whether or not parents feel that someone understands their child's difficulties. We asked parents of children with speech, language and communication difficulties *"In the nursery or school, who do you feel understands your child's difficulties?"* In Table 6.1, we compare the number of parents who chose class teachers and SLTs as understanding children's difficulties. This varied across locations and perhaps reflects how parents perceive their child's difficulties, the amount of time different professionals spend in contact with children/young people, and the style of delivery of speech & language therapy provision in each location. Most parents chose more than one person; many considered that learning support teachers, nursery nurses, and classroom assistants, and to a lesser extent head teachers, understood their child's difficulties.

Table 6.1 Parents who felt class teachers and speech & language therapists understood their child's difficulties

Location	Who understands your child?*	
	Class teacher	Speech & language therapist
Mainstream nursery (76 parents)	(74%)	(42%)
Mainstream primary (96 parents)	(70%)	(53%)
Mainstream secondary (11 parents)	(36%)	(55%)
Special school/unit/class (206 parents)	(88%)	(83%)

*Parents chose all that applied, therefore numbers are not mutually exclusive

For pupils in mainstream nursery and primary schools, the class teacher was chosen by parents more often than the SLT as someone who understood their child's difficulties (although many felt that both did). Parents, naturally, see their child as a whole person rather than as a set of difficulties, therefore they may feel that the people who spend most time with their child will be the ones who understand them best. In special educational facilities, many SLTs spend more time in the school than their colleagues in mainstream settings, and often work in the classroom in close partnership with teachers. It is hardly surprising that parents feel these SLTs are just as likely to understand their children as the class teacher. It is worrying that parents of young people in mainstream secondary school have such a low rate of confidence in both teachers' and SLTs' understanding of their child's difficulties. However, this is a small sample, and these young people are most likely to be those with severe and persisting difficulties, so the views of these parents may not be representative of all parents with secondary pupils who have speech, language and communication difficulties.

We may infer that parents perceive their child's education as the central feature of their life outside the home, and that this is where their needs should be met. Parents do not see speech, language and communication in isolation and are more concerned about how their child's difficulties affect them in real life. Although they may attribute to the

---

[20] A system of manual signs used for communication.

107

SLT the responsibility for improving their child's speech, language and communication, they expect her to set goals which make sense for their child as a whole. These goals need to be understood and supported by all those involved with the child. Parents, and professionals from different disciplines, are unlikely to share a common view of whether or not intervention has been successful, unless they have been jointly involved in setting goals. This leads once again to the issue of collaboration, and its part in determining the role of the SLT in the education of pupils with special educational needs.

Collaboration, joint working and working alone

> "There are some tasks that one person, working in isolation, cannot do. Such a task is to support children with special needs and their families. The sheer complexity of need coupled with the way in which services are constructed in this country make it impossible for any one person to manage this task alone. Effective teamwork can lead to better service provision, increased energy and progression, and greater job satisfaction. A well co-ordinated team can, in many cases, lead to better use of individual skills and more effective implementation of resources especially when there is a danger of duplication or of children 'slipping through the net".
>
> (Lacey & Lomas, 1993: p. 142)

Since the Warnock Report, collaboration among different professionals and parents is recognised as effective and beneficial in the field of special educational needs. There is no one official body or agency wholly responsible for children/young people with special educational needs, as needs are so diverse and no one professional could meet all of them. However, the needs of the 'whole child' must be met. It is not acceptable for different professionals to concern themselves only with 'bits' of the learner, for example, ears, hand function, language skills, mobility; the child needs an integrated programme of learning and therapy. The rights of the child or young person may be better protected if more than one person works together to meet her/his needs and recognition of this is enshrined in the Children (Scotland) Act 1995. The Parents Charter (SOED, 1991) specifies that parents have the right to expect that the special needs of their child will be met. Collaboration confers advantages to the professions as well as to the child/young person and her/his family. Problem-solving may be more productive and innovative if tackled as a team, rather than as individuals working in isolation. Professional development is likely to result from joint assessment, planning, and joint working. Job satisfaction may increase, and stress diminish, where individuals are not working in isolation.

As discussed in Chapter 3, almost every SLT who participated in this project considered that they collaborated with teachers as part of their work with pupils with special educational needs. In addition, a majority of teachers who have contact with pupils receiving speech & language therapy reported that they were involved in all or some of these activities:

- Reporting and feedback from teacher to SLT and/or from SLT to teacher
- Observation of SLT's work by teacher, and/or of teacher's work by SLT
- Joint planning and joint work, with SLT, on educational programmes and/or on speech & language therapy programmes
- Guidance and advice from teacher to SLT and/or from SLT to teacher

The most common activities reported by teachers were SLTs giving guidance and advice to teachers, and SLTs giving reports and written feedback to teachers.

If a teacher and SLT work jointly with pupils some or all of the time, this may be taken as evidence of a high degree of collaboration. It is hard to imagine a teacher and SLT who work jointly with pupils but who have not planned together or are unfamiliar with each other's approach. Working jointly is promoted by specialists in both the teaching and the speech & language therapy professions as "best practice" in the case of pupils with severe and enduring speech, language and communication disorders (Wright & Kersner, 1990). A recurring theme in modern educational policy is for ***all*** support work to be carried out in the classroom, although we found that individual classroom teachers did not always agree. Depending on the number and range of pupils who have identified special needs in a class, class teachers can find themselves attempting to collaborate with a number of visiting specialists such as teachers of the deaf or behavioural support teachers, as well as SLTs, learning support teachers, educational psychologists and perhaps one or more classroom auxiliaries/assistants. It is clearly not feasible for a class teacher to work in ***close*** collaboration with all of these people.

It must not be assumed that 'working alone with pupils' necessarily implies less collaboration or less effective collaboration, although our survey of SLTs suggested that, for many SLTs working in mainstream schools, this was indeed the case. It could be argued that if teachers and SLTs have a clear understanding of each other's role, and a mutual respect of each other's skills, and if joint assessment, joint planning of integrated therapy and educational programmes takes place, it may be immaterial who actually delivers the programme. We saw good examples of this on visits to schools. In one special school, although SLTs and teachers tended not to work jointly, there was a whole-school commitment to a framework of assessment, planning and record keeping which was shared between education and speech & language therapy.

Withdrawal from class for individual or small group therapy may be the best method of therapy with certain pupils in certain situations. Such cases will include:

- Pupils receiving therapy on a less than intensive basis, whose speech, language and communication difficulties are relatively minor and are resolving, and therefore do not affect classroom/curriculum work unduly
- Older pupils requesting privacy
- Pupils with fluency problems
- Pupils with particular problems of attention control
- Pupils working on a very specific task unrelated to classroom activities
- Pupils using special equipment which might be distracting to others

Our data suggest that a high degree of mutual understanding and co-operation thrives in situations where SLTs and teachers spend a lot of time together, and where there is usually some joint working. Overall, the more SLTs work alone, the more probable it is that a lesser degree of collaboration is the norm.

Most of the SLTs surveyed indicated that they worked collaboratively with parents, either directly or indirectly, irrespective of the location in which children/young people were receiving speech & language therapy, and parents were often cited as the ones who continued speech & language therapy programmes. Some measure of collaboration with parents was almost universal where children/young people received speech & language therapy services in health centres, clinics or other NHS premises, which, according to our surveys, is where 35% of all under-18s receive speech & language therapy services. This collaboration with parents may be invisible, or overlooked, by teachers. However, at least some of the teachers surveyed were very aware of this aspect of SLTs' work, and felt that their involvement in the pupil's therapy programme could not match parental involvement in terms of time, effort or potential impact on the child:

> *"I feel it is very difficult for the teacher to include speech and language therapy as part of her remit in a busy classroom. I have seen children who attend speech therapy outwith the classroom thrive and question how successful the joint therapist and class teacher would be, due to lack of time."*
>
> (Primary 2 teacher)

Because withdrawal is the traditional style of therapy and, according to our surveys, is still the most prevalent approach in mainstream schools, it tends to be viewed as 'the norm' by teachers and parents alike. We believe that this is a major stumbling block to a full understanding of the potential role of the SLT, which will impede further progress towards effective provision.

If 'joint working' is used as an indication of a stronger style of collaboration, our survey of SLTs suggests that this type of collaboration happened always or almost always:

- In special educational facilities for pupils with physical disabilities
- In special educational facilities for pupils with specific language disorder
- In special educational facilities for pupils with pervasive communication disorders (autism)

and usually

- In special educational facilities for pupils with learning difficulties
- In special educational facilities for pupils with hearing impairment

Joint working was less common in mainstream settings (see Chapter 3). It seems likely that it is in special educational facilities that collaboration is both more prevalent and stronger in style. In one special school we visited, a teacher commented that people visiting the school, parents in particular, didn't always know which team member was the teacher, which the SLT:

> *"People often confuse us with each other. I think that's good."*

Through our surveys and our visits we encountered some clear indications that mainstream schools can be a hostile environment for pupils with speech, language and communication difficulties. This is particularly the case in secondary schools. For example, we came across pupils who had been asked to leave classes by subject teachers who were not prepared to take any steps to differentiate the curriculum for them; secondary school teachers whose only concept of how a SLT might work in the classroom was as a *"super care assistant"*; and members of a secondary school management team responsible for special educational needs who felt that speech & language therapy was nothing to do with them. The level of understanding of speech, language and communication difficulties in mainstream schools was often virtually absent, as illustrated in the following quote:

> *"Why as a parent of such a child have I to always fight for help, and get help eventually. At his mainstream school, I have to make a nuisance of myself before I get anywhere. When he had to go out and get speech therapy, it was always a hassle. My son has been back [in mainstream] for nearly 2 1/2 years. I feel the school is ashamed to have such a child in the school. He has been the first child to go out and be educated at a special unit. He may be no use at 'educational', but he has other things he can do. My hope is that when he attends secondary school things could be better. A visiting music teacher … called my son an 'idiot', she asked did he understand what she was saying, no he replied* [as he had been taught to do], *you are just an idiot.* [She also] *upset other children in the room."*
>
> (parent of 10 year old with specific language impairment)

Effective collaboration

We know that some level of collaboration among SLTs, teachers and others is taking place in each of the different types of educational settings in Scotland. In recent years there has been increasing recognition of the importance of collaboration, especially between SLTs and teachers, but also among other members of multidisciplinary teams such as learning support staff and educational psychologists. Collaboration is taking place, but what is the *quality* and *effectiveness* of that collaboration, and how may that quality be assured, maintained, and enhanced?

The term 'collaboration' is often used to refer to any situation in which two professionals meet and exchange information, this would include a range of activities from regular, formal planning meetings to occasional coffee-break chats and from SLTs providing teachers with feedback to joint working with pupils.

In some speech & language therapy services, there has been a move in recent years for SLTs to act in a *consultancy* role in certain therapy locations, particularly in locations where the potential caseload may be too large to allow the SLT to have sufficient direct therapy input (see, for example, case study school B in Chapter 4). This is a 'top down' approach where the SLT assesses and gives advice, and may devise programmes of work to be carried out by other staff or by parents. While it may work in some therapy settings, this concept, and the term *consultant* itself, is unhelpful. The term carries medical overtones and connotations of 'special expertise'. Both of these, it may be argued, may be alienating to teachers and parents. Use of educationally orientated terminology might be more acceptable. For example, SLTs might redefine themselves as a 'resource' for schools. If the role of 'expert' is considered to be a useful one, the term 'Speech & Language Therapy Adviser' might be more comprehensible and acceptable to teachers.

A number of terms, such as 'multidisciplinary', 'interdisciplinary' and 'collaborative', are applied to describe team-working. Working alongside other professionals in a team may be co-operative, but may not necessarily involve much communication or joint working among team members. Some approaches may involve parents and children in a degree of unnecessary duplication and overlap, for example, when each member of the team assesses the child/young person individually from their own professional perspective.

Other collaborative approaches result in a more equal relationship between two or more partners, with each supporting the others, in order to achieve a mutually determined goal. This type of collaboration implies more of a 'bottom up' approach. In her study of collaboration between SLTs and teachers, Wright (1995) found that in her sample of over 400 SLTs in England & Wales collaboration was reported to occur only on certain activities: assessment tended not to be undertaken collaboratively, whereas collaboration was fairly common for programme planning and even more common for intervention activities. These data relate to SLTs' reports of their collaboration with class teachers, and the measures are not directly comparable to those adopted in our study. However, the trends in the data from our study are for the teachers to report more joint planning than joint working with SLTs.

Ideally, we would argue, collaboration is a process which begins with joint assessment of pupils, and progresses through joint identification of common goals and joint planning of educational and speech & language therapy programmes. The delivery of these programmes to pupils may or may not be carried out jointly. As argued above, joint working should not be regarded as a necessary component of effective collaboration. Nonetheless, joint working can be a valuable way of 'modelling' and helping teachers and SLTs to evolve compatible styles of working, so that pupils experience an integrated programme rather than a series of diverse approaches:

> '[The speech & language therapist I work with] *appreciates the heavy workload teachers have, the drive to widen ever further the Special Curriculum & the individualities of different teachers. At the same time, however, she inspires teachers to be reflective and offers her expertise for the maximum benefit of both pupil & teacher. Before my experience with this particular therapist, I always regarded speech therapy as some magic formula which was applied in a quiet room. Now I have come to appreciate that the value of her work is quadrupled (at least!) if the class teacher has an understanding of it, shares in it and continues along the*

same lines during the rest of the week. The proof—if any is needed—is that I've seen pupils progress in an impressive manner, and so have their parents."

(Teacher in a special school for pupils with learning difficulties)

"I personally find the collaborative classroom based approach works best for the three pupils in my class [who get speech & language therapy]. It means that both teacher and speech/language therapist are aware of the day to day needs of the child and problems can be discussed and resolved on a daily basis. The results from this approach have been, I feel very successful, particularly with children who have previously failed at literacy."

(Teacher in a special school for pupils with physical disabilities)

In Wright's (1995) study, reciprocity between teachers – SLTs pairs was found to be much more strongly associated with an increase in knowledge ('cognitive gain') as a result of working together than any other factor. Many of the teachers and SLTs interviewed during the present study highlighted mutual 'cognitive gains' as a very important benefit resulting from collaboration, and frequently these reports were linked with perceptions that pupils showed better progress in such an environment, thus encouraging staff to develop further their collaborative approach. 'We tried a little, it worked, so we tried some more,' seemed to be a very common theme.

Barriers to collaboration

Full-scale collaboration may be difficult to achieve, and most education and health care professionals and support staff have no training in it. Tomlinson (1982: p. 31) suggests that the degree of extended multi-professional collaboration (for assessments) advocated by the Warnock Report "assumes an unrealistic degree of communication, co-operation and absence of professional conflicts and jealousies". Lacey and Lomas (1993: p. 1) point out that although it is easy to argue the need for a unified and integrated approach to pupils with special needs, making it happen in practice is quite another matter: "It is not enough to exhort professionals to work together and then leave them to it. Staff need both time and training to make the most of each other's skills and experiences."

Wright (1995) found that in her sample of over 400 SLTs, the most frequently mentioned factors contributing to successful collaboration included those in the following categories: appreciation (including mutual respect), motivation, time, mutual goals, regular contact, perceived management support. These factors in the negative were also cited as those most likely to inhibit collaboration.

The following areas of difficulty were highlighted during the course of our own interviews:

- **Different working conditions**
  Education staff and SLTs work for different employers with different working hours, holidays, status, pay scales, conditions of service, funding mechanisms, professional ethics and 'rules and regulations'. Individuals may be unaware of how different their conditions are from those of their colleagues in other disciplines. In some cases, they may find specific differences a source of friction. Teachers find it irritating that SLTs can be absent from school during the school day; SLTs envy teachers' long holidays and shorter working hours.

- **Professional barriers**
  There may be 'historical' barriers between professions, vested interests and feelings of insecurity or jealousy (see, for example, the discussion of speech & language therapy in schools for pupils with hearing impairment in Chapter 5). Specialists may feel that if they share their knowledge and expertise, they may be 'doing themselves out of a job'.

- **Jargon**
  Professions may become entrenched within their own terminology, making communication difficult. (Much of the 'jargon' of the speech & language therapy profession is foreign to most teachers and parents.)

- **Autonomy**
  Professionals who are used to working autonomously may feel threatened by having others observe their work, and by working with others. Potential loss of autonomy and 'professional exposure' were also cited by Wright (1995) as 'costs' of collaboration as perceived by SLTs and teachers.

- **Lack of training in collaborative practices**
  There is little if any pre- or post-qualification joint training available to teachers and SLTs in working collaboratively.

- **Bureaucracy**
  Collaborative decisions and courses of action can be difficult to implement because of financial implications stretching across different agencies and budgets. This can generate delays and burdensome paperwork, and may be made worse by the current move to smaller and more fragmented services.

- **Membership of several teams**
  Some professionals, SLTs in particular, have large caseloads and may be members of many different teams. This can lead to conflicting demands upon their time and divided loyalties.

- **Confidentiality**
  Professional ethics and codes of practice on confidentiality can make it difficult to share information. Medical, therapy and psychological records are not available to teachers to read, and many teachers often feel they are receiving inadequate or 'third hand' information about the pupils whose educational needs they are responsible for meeting.

- **Lack of 'team play'**
  Some individual teachers and SLTs do not perceive themselves as members of a team. There may be many possible reasons for this; for example, they may not have enough time in any one establishment to meet, let alone work with, other people.

- **Lack of time**
  This is a major problem for *all* professionals working with pupils in education, both those within the same building each day with large groups of pupils to cater for, and those who have only a few pupils to deal with in each location, but who have to cover a number of different locations, perhaps across a large geographical area. Collaborative working is not a 'short-cut' and indeed may take much longer than working in isolation, which may frustrate some people.

In summary, collaboration is governed by a complex interaction of many factors. It cannot be guaranteed just by having different disciplines 'cohabiting' within the same institution. All SLTs surveyed felt that they were collaborating to some extent with teachers, which would indicate that they are aware of the importance of collaboration. However, our visits and interviews demonstrated that SLTs and education staff were affected to a greater or lesser extent by *all* of the above problems. The extent, quality and effectiveness of collaboration suffered as a result. In some schools, collaboration may exist only at a 'token' level.

If collaboration is lacking, the fault must not be attributed just to the 'personalities' of individual professionals. Although many of the difficulties listed above can be overcome by personal commitment, dedication and goodwill, it is not reasonable to put all of this burden upon individual professionals. Commitment, dedication and goodwill need to come not only from individual class teachers and SLTs but also, at an institutionalised policy level, from their managers and employers. Teachers and SLTs may not have the power to change how they work in the ways necessary to enable effective collaboration. Their managers and employers need to recognise the importance of collaboration and give priority and active support to collaborative initiatives.

In the field of special educational needs, difficulties in collaboration are not exclusive to the relationship between the speech & language therapy and teaching professions. Effective collaborative working relationships *within* education are also difficult to achieve, and we came across examples of this both in the literature and on our visits. We learned of schools where educational psychologists were excluded from all school-based meetings on the grounds that they did not know the pupils well enough to make a useful contribution, and because of this they upset parents and other staff. Allan, Brown and Munn (1991) found that misperceptions of roles exist between learning support staff and class teachers, and that both primary and, especially, secondary teachers were often hostile, at least initially, to the presence of another teacher in the classroom. Lacey & Lomas (1993) report many cases of quite extreme misunderstanding between visiting specialist learning support teachers and members of school staffs.

As we have discussed in Chapter 3, our surveys have provided evidence that collaboration between SLTs and education staff is more frequent and more varied in special educational facilities than in mainstream schools, and it is difficult to believe that the relatively minimal differences in average caseloads or number of locations covered by SLTs can account alone for this finding. 'Cultural' differences may also be influential here. The culture of a special educational facility contains, to some degree at least, an expectation of collaboration among staff, whereas we may hypothesise that the culture of the mainstream school is more likely to inhibit than to facilitate collaboration unless overcome by particularly strong-minded or unusual individuals.

Collaboration in Scotland in the 1990s

Do teachers, SLTs and parents understand and respect each others roles?

Most commentators agree that for successful collaboration to take place there needs to be mutual understanding of the training, philosophy, knowledge base, skills, experience, conditions of service and the degree of freedom, or the constraints, under which other individuals work. Poor understanding about each other's roles may lead to false expectations about what each can do. Many of the teachers we interviewed had come to realise this, in relation to the role of SLTs:

> *"Parents – and others – have unrealistic expectations. There is a general perception that speech therapists have a magic wand to wave over the child and cure him"*
> (Head teacher of a special school for pupils with learning difficulties)

This same 'magic wand' phrase came up, quite independently, in relation to SLTs, in a number of our interviews. People *want* SLTs to have a magic wand, and have never quite accepted that it is not true!

On our visits we found that a high level of mutual understanding and respect (what Wright (1995) refers to as 'appreciation') co-occurred with work which those involved perceived to be 'good practice'.

Understanding what speech & language therapists do

In special educational facilities there may be a higher ratio of SLTs to pupils, SLTs may spend relatively more time in the school, and SLTs and teachers may spend more time together. Teachers, therefore, may acquire a good understanding of what SLTs do. However, particularly in mainstream schools, awareness amongst teachers may be lacking. Old fashioned stereotypes persist, stereotypes of 'elocutionists' or in the case quoted by Gower and Sisson (1994), 'ventriloquists'!

A regional special interest group of SLTs working in education carried out a survey of 100 special needs co-ordinators in primary schools in the West Midlands . They asked, for example, "What does a speech & language therapist do?"; "What is their training?"; "What clients do they see?". There was a substantial mismatch between the SLTs' views and those of the teachers on the role and effectiveness of SLTs. For example, only 29% of teachers thought that SLTs dealt with language; 63% thought only speech problems were dealt with. Most teachers believed that speech/articulation cases should always be a priority. As the SLTs who had conducted this research felt that SLTs could not be effective in schools until these misperceptions were changed, they published an article explaining the role of SLTs in a publication widely read by teachers of pupils with special educational needs (Gower & Sisson, 1994).

In their initial training, teachers receive very little input on speech, language and communication and are unlikely to have received input on speech & language therapy. Many teachers in training or newly qualified teachers will never have met a SLT and will have little idea of her role in the education of pupils with special educational needs. Historically, many pupils with severe communication disorders would have been educated in special schools, so mainstream teachers may have little experience of pupils with these types of difficulties. They may be aware of the fact that a SLT serves or visits their school, but they may have no direct contact with her. Additionally, staff changes may inhibit the development of relationships.

Although many of the teachers we interviewed had little knowledge of what SLTs do, those teachers who had trained and worked as specialist support teachers, especially those who had worked in a peripatetic way, demonstrated a good understanding of how SLTs work and the difficulties they face. Some of these support teachers said they often felt they had more in common with SLTs than with class teachers. Shared experience is a major facilitator of mutual understanding. An ex-peripatetic teacher reported:

> *"I have a lot of sympathy with speech and language therapists as I have experienced the pain of being 'extraneous". You always feel uncomfortable, as though no-one really wanted to know you. It's not easy. Getting to know school staff is impossible – you need to be there over lunch. Mind you, in big secondary schools, half the staff don't know each other anyway."*

Lacey (1995: p. 59), talking of educational support services, described their working life in terms that could apply equally accurately to SLTs. "Many such professionals spend hours travelling, live out of their boxes and cases and are constant visitors in other people's domains."

Other research in England has revealed negative and critical attitudes amongst teachers towards SLTs. Anderson, Constable and Graham (1990) surveyed teachers who felt that SLTs 'dashed in and out'; had no idea what it was like to have a class of 30 pupils; offered suggestions that simply could not be carried out in a classroom; and sometimes acted in a 'high handed' manner that demeaned teachers. One of the teachers interviewed by Daines (1992: p. 22) offered: "I don't know what she does with him. He needs to learn how to speak in here not in that room". These criticisms and misunderstandings appear to arise from a mismatch between the medical model associated with SLTs, and an educational model.

Few criticisms of this type were expressed in our surveys and interviews, which is a tribute to the efforts made on all sides to improve services to pupils with special educational needs in Scotland. The Secretary of State's Initiative may have helped, by providing additional funding and a new focus on speech & language therapy in education:

> *"Well, I suppose if they are paying for my time, I have to work the way they want me to, more or less. It's good, really, because I have more time in the school now, so I am getting to know better how it all works."*
>
> (SLT employed through 'education contract')

Substantial numbers of the teachers surveyed expressed worries about how busy SLTs always seem to be and how little time they have available to spend in the school or with the pupils.

> *"My speech therapist is excellent, but due to a busy schedule, can only come to [the school] for 1 hour per week. [Geographic area] Regional Council obviously needs more therapists."*
>
> (Teacher in special school for pupils with learning difficulties)

> *"I would like to register that the therapist in our school is a dedicated and enlightened worker, who is at ease with staff, pupils and parents. She sets the best example of her role, and tries to fulfil the needs of all the children in the school, but is restricted to giving help to the most impaired, by lack of time. She would have to jeopardise the time she spends with these few children, if she were to attend all the multidisciplinary meetings she could/should attend. Instead she writes notes for meetings she cannot attend in person which is very time-consuming."*
>
> (Teacher in a special school for pupils with learning difficulties)

Lack of time may make it impossible for many SLTs to collaborate effectively. Where there were negative comments made about speech & language therapy or SLTs, these tended to relate to problems in communication:

> *"...communication between speech therapists and nursery – at present no official communication, and we only know if children are attending the clinic if the parent wishes to choose to tell us in nursery".*
>
> (Nursery teacher)

> *"I have no one at present in my class of 31 Primary 5s who needs the services of the speech therapist ... on previous occasions when children have been referred and continue to use the service, as a class teacher I feel very unsure of what is being done. There seems to be little or no liaison with class teachers apart from an official letter to say that therapy will commence. When children have very marked speech defects I would appreciate advice on the nature of the defect and how I as permanent class teacher may assist."*
>
> (Primary 5 teacher)

> *"As a class teacher I may not be informed if a child is receiving speech & language therapy at a clinic rather than in school. I think that it would help to know of all those of your pupils who are in need of therapy, and of their progress."*
>
> (Primary 2 teacher)

Increasing the ***time*** available for contact between SLTs and teachers would enhance collaboration. This requires 'official' recognition by speech & language therapy managers and head teachers. The desire for more formal arrangements for liaison time with SLTs came out clearly from the results of our survey of teachers; 60–70% of mainstream teachers and 40% of teachers in educational facilities for pupils with learning difficulties saw this as a need.

Understanding what teachers do

Understanding education presents different problems. On one level, everyone knows what schools are for, what a teacher is, and what s/he does; there is little need for the basic principles of teaching to be spelled out. However, most people are much less certain about the day-to-day programme in school classrooms; the new 5–14 curriculum; individual educational programmes (IEPs); their local education department's policies on special educational needs; policies and practices relating to Records of Needs; or the philosophy of a particular school on how special educational needs should be met. In the absence of this information, SLTs, parents and others may fall back on stereotypes and their own childhood experience of school.

Unless they undertake a teaching qualification or a specialist post-graduate course, SLTs currently receive little information about the knowledge base of teachers; about the curriculum; the role of different types of teachers; how different teachers operate within schools; and the organisational structure of schools. This means that many SLTs do not have sufficient understanding of how individual teachers set goals and priorities for a child, how they 'differentiate' or individualise the curriculum, and, therefore, in what form a teacher could best use speech & language therapy input.

In addition, SLTs generally have more experience of primary schools than they do of secondary schools, so they may be even less aware of the role of secondary school teachers and the organisational structure of secondary schools.

Do parents feel they are part of the process of collaboration?

In our survey of parents, we asked them about the sharing of information about their child and her/his therapy needs. Out of 520 respondents:

- 84% felt adequately included in decisions made about their child
- 76% felt that overall they had had good information about their child's difficulties

As a measure of collaboration in programme planning and assessment, we asked parents, "Who decides what your child is working towards in therapy?"

- 47% said the SLT involved them when deciding (many of these same parents said the SLT also consulted the teacher) but 22% said that the SLT decided on her own

In relation to their child's education, we asked parents whether they had been involved in devising their child's individual educational programme if s/he had one. 201 parents said their child had an IEP; 209 said they did not; 81 were not sure; and 29 did not answer this question. Of the 201 whose children had IEPs:

- 22% said they had been included in the devising of the IEP, and 76% of these (34 out of 45) reported that the SLT had also been involved
- 78% said the SLT had been involved in the IEP, whether or not the parents had been

While relatively few parents felt involved in decisions about educational programmes, nearly half seem to feel involved in decisions about speech & language therapy. A large number of parents felt that SLTs were involved in educational planning, suggesting that they viewed the SLT and teacher as working together.

Parents were also asked how involved they were in other aspects of their child's speech & language therapy. Many (59%) help their child with homework that the SLT sets and similar numbers encourage their child to use new communication skills in everyday life (53%). Fewer actually watch therapy sessions (10%), take part in planning therapy or making suggestions about activities for therapy sessions (9%), or join in therapy sessions (7%).

As another measure of the strength of collaboration with parents, we asked how parents kept in contact with their child's school and whether they received written information from school about their child. Most parents used several different systems for keeping in contact:

- Parents Evenings – 57%
- Home-School diary – 53%
- Arranged meetings with child's teacher – 34%
- Chats with teacher, when picking child up from school – 25%
- Chats with teacher, at least once per week – 8%

Although schools are obliged to provide parents with written reports on their children, not all parents ticked this item. However, most did report that they received some form of written report from school, including reports from the SLT.

We also asked parents how they kept in contact with what their child was doing in speech & language therapy. Parents of younger children and those receiving clinic-based therapy usually had contact with the SLT at most sessions. Parents of children/young people receiving their therapy within schools had contact less often, and used a variety of methods such as meetings, home-school diaries, written reports and telephone contact. 97% of the parents whose children were receiving speech & language therapy indicated that they had some contact with their children's SLT.

How do parents view collaboration between professionals?

Parents may find it quite difficult to see how the roles of different professionals fit together, and who is accountable to whom. 217 parents who participated in our survey (42%) said they did not know who to contact if they were unhappy about the speech & language therapy service their child was getting. 49% said that they did know; they mentioned a wide range of people (including the midwife!), but the most commonly mentioned were head teachers and educational psychologists, rather than speech & language therapy or health service managers. Many parents appear to perceive speech & language therapy services as part of education, perhaps in part because of increased awareness of the responsibilities of education authorities.

In the questionnaire to parents, we asked whether they felt satisfied with the sharing of information that went on *among* all the professionals dealing with their child. 69% said that they felt satisfied, 20% were not satisfied, and others were not sure. From our original interviews with a group of 12 parents we gained the impression that they were, in general, unaware of the information which was or was not shared among professionals. The only point at which this may have become an issue for them was if they noticed an incident, either positive or negative, affecting them or their child's therapy which seemed attributable to a lack of inter-professional communication. One of the most common situations cited by these parents, usually as a charge levelled against doctors rather than against teachers or SLTs, was that of having to go over the child's case history repeatedly to different people who do not seem to have read the case notes.

Our interviews highlighted the need for effective contact between schools, SLTs and parents. Some schools and SLTs made a special effort to ensure that whenever parents visited the school or the class, either for meetings, Record of Needs reviews, or Parents' Evenings, they saw their child's teacher and SLT *together*. This gave parents the message that their child was receiving a co-ordinated and integrated programme of education and therapy and showed that the SLT was part of the school team.

In contrast, in most schools, although parents visited and talked to both teachers and SLTs, this was often on two separate occasions. Many schools had never considered inviting the SLT to be involved in Parents' Evenings. Some SLTs said that they were not given notice of Parents' Evenings, or only received a casual invitation at the last minute. Some SLTs said they felt it was not a good use of their time to see parents in this way, and that they preferred interviews where they could discuss the child's therapy at greater length. With regard to more formal case-conference or Record of Needs review meetings, SLTs were usually notified in good time and included. Nevertheless, some SLTs commented on how hard it was for them to arrange to get to every meeting for every pupil on their caseload *and at the same time* fulfil their contracts for face-to-face contact with pupils.

Summary and conclusions

In this chapter, we have argued that effective collaboration (amongst professionals and with parents) is central to the effectiveness of speech and language therapy provision for children with special educational needs. Drawing on data from our surveys and interviews, along with the research findings of others, this chapter has:

- Explored parents' views of speech and language therapy, in order to obtain a 'consumer satisfaction' measure of effectiveness
- Analysed the nature of collaboration
- Discussed potential barriers to the implementation of effective collaborative practice
- Assessed the extent of collaboration and the degree to which respective roles are understood among SLTs, education staff and parents

Parents' comments about the quality of their children's speech and language therapy were predominantly positive, in our survey. Most parents simply wanted more therapy time for their child, although some wanted qualitative changes such as more individual work, more group work, a more local service and better continuity of provision. Thus, while 'consumer satisfaction' was high overall, it is important to recognise that the effectiveness of any particular form of provision will vary according to the needs and circumstances of the individual child.

Collaboration between SLTs and teachers takes a variety of forms and does not necessarily involve working jointly with pupils. Nevertheless, our data suggest that mutual understanding and co-operation tend to be greatest in situations where joint working is common and therefore that joint working can be used as an indicator of a stronger style of collaboration. On this basis, collaboration between SLTs and other professionals was found to be stronger in style (as well as more prevalent) in special educational facilities than in mainstream settings.

The extent, quality and effectiveness of collaboration are influenced by a complex interaction of many factors. Although some of these factors relate to the 'personalities' of individual professionals, many of the barriers to effective collaboration (e.g. lack of time, lack of training in collaborative practices) need to be addressed at an institutionalised policy level by managers and employers.

In our study, teachers varied in their understanding of SLTs' roles, with those who had trained as specialist support teachers usually showing the greatest understanding. Teachers were less critical of SLTs in our study than in previous studies in England, and those criticisms which were made usually related to communication problems due to lack of time available for contact. SLTs' understanding of teachers' roles also varies according to their training and experience, but many SLTs would benefit from more knowledge about education (e.g. in relation to the curriculum, educational policies and the organisational structure of schools). Parents' responses to our survey indicate that, on the whole, parents feel they are part of the process of collaboration regarding their children's speech, language and communication needs.

CHAPTER 7

The way forward

The present study has shown that the role of speech & language therapists in the education of pupils with special educational needs is extremely complex. It varies, for example, with respect to the locations in which therapy is provided; the funding available to provide services; the amount of time spent in each school; the ethos of different schools; the education, experience and belief systems of individual therapy managers and SLTs; the education, experience and styles of working of individual members of education staff; the quality of collaboration achieved among different professionals and parents. These 'structural' factors often seem to have a greater influence on the role of SLTs than does the age or level of learning difficulty of individual pupils, or the particular types of speech, language and communication disorders from which they may suffer.

In spite of fundamental differences of professional education and background amongst those working with pupils with speech, language and communication difficulties, and more superficial differences of approach, there is a consensus that speech & language therapy is a necessary and valuable part of the educational process for many pupils with special educational needs, and that it works best when it is closely integrated with the day-to-day work in the classroom. As already discussed, many SLTs, teachers and parents are trying very hard to collaborate. To make further progress, more support is needed from higher levels of management and administration.

Is there still an overall need for more resources for speech & language therapy services in education?

The present study's findings indicate a widespread view that more resources for speech & language therapy are needed. Chapter 6 discussed the responses of parents to the question: "In what ways could your child's speech & language therapy be better?" Most parents wanted more input, in the form of more sessions, more regular or more frequent sessions, or increased SLT time in the classroom. Many professionals, both in survey responses and interviews, also voiced the opinion that more speech & language therapy time was needed, or more SLTs, both for direct work with pupils and for collaborative work with education staff. SLTs also felt under pressure in much of their work in schools. A community SLT is likely to have 60 or so children/young people on her caseload[21] and she may compare these numbers unfavourably with those of, for example, the pre-school home visiting teacher, learning support teacher or specialist language support teacher with whom she collaborates.

For parents and professionals, it may seem 'obvious' that more SLTs are needed, or that an individual pupil 'needs' more speech & language therapy. However, it cannot be assumed that the demand for services is equivalent to the need. Resources for speech & language therapy, like resources for education or any other public service, will always be limited. A principled approach to allocation of resources is required and this is likely to mean that some objective or quasi-objective methods are required for measuring and comparing 'need' across individuals in different client groups. It may be argued that scarce resources are better targeted towards those who can make 'best use' of such resources, rather than attempting to spread resources equally across all potential clients but too thinly to make an impact. A case for increasing overall resources is unlikely to be convincing without evidence of both 'value for money' in the allocation of resources to speech & language therapy services, and the efficacy of speech & language therapy in improving the circumstances of children and young people with speech, language and communication difficulties.

---

[21] The figure of 60 is based on the median caseloads, presented in Chapter 3, of SLTs working in mainstream schools and other locations.

While there is a need for scientific evidence on efficacy, it should be recalled that in an educational context, efficacy studies need to measure changes in the delivery of ***education*** to pupils with speech, language and communication difficulties, as well as changes in their speech, language and communication skills *per se*. For many pupils with severe speech, language and communication difficulties, the aim of speech & language therapy may not be to 'cure' or even to ameliorate their difficulties, but rather to improve access to an educational curriculum. The primary outcome measure in such circumstances is likely to be a more appropriately differentiated and elaborated curriculum or better individualised educational programmes rather than changes in fundamental speech, language or communication skills (although changes in these may also result). 'Cross-disciplinary' outcome measures of this nature have not yet received sufficient attention, and it is difficult to see how, in the current system, they might be reconciled with the outcome measures demanded of SLTs by NHS Trusts.

In order to specify requirements for speech & language therapy, objective methods for identifying and comparing the 'needs' of different client groups are required. How can a principled decision be made to target resources towards one client group, when this almost inevitably entails less resources available for one or more other client groups? Again, systematic studies in this area are needed. Such studies would provide a highly relevant focus for research collaboration between education and health sectors.

Systematic studies of the cost-effectiveness of different methods or models of delivery of speech & language therapy services are also required. Because of the geography of Scotland and other constraints on speech & language therapy services, different models of service delivery to schools have arisen naturally; the opportunity therefore already exists for comparative studies. Without such studies of efficacy and cost-effectiveness, the case for increased resources will remain unclear.

The organisation of speech & language therapy services to education

Within the speech & language therapy profession, review of a number of issues might facilitate work in education. For example, there is a need for guidelines on appropriate caseloads for SLTs working in schools. Caseload guidelines for SLTs working in schools need to take account of the differences between school and health settings. The relative importance in school settings of indirect therapy work and collaborative efforts, as contrasted with direct one-to-one therapy, may necessitate a rather different set of statistical returns, outcome measures and overall audit formulae.

The original intention of the Secretary of State's (1991) Initiative was to allow education authorities to purchase the level of speech & language therapy services to pupils with a Record of Needs being provided by health to these pupils at the time of the Initiative. However, at the time of the present study, not all speech & language therapy to pupils with Records of Needs was being provided under an education contract. It may be that the resources provided centrally were insufficient for their purpose, or that education authorities failed to receive their full allocation from regional councils, as was the opinion of some of those interviewed in the present study. However, it is also possible that the speech & language therapy services being provided to schools prior to the Initiative were below the level at which subsequent contracts were drawn up. After all, if an education authority is contracting for a service, it is unlikely to do so on the basis of what is perceived to be a less than adequate level. Moreover, as the service through education contracts was to be provided ***in schools***, it is likely that because of increased costs associated with this type of service, (e.g. time spent in travelling), the same amount of money 'bought' less actual speech & language therapy time.

According to our surveys and interviews, speech & language therapy managers were of the opinion that the original level of funding barely covered the demand for services at the time of the implementation of the Initiative. If more and more children/young people acquire Records which specify a need for speech & language therapy, without equivalent numbers of young people either leaving school or no longer requiring speech & language therapy, the same level of funding will cover a smaller proportion of the children/young people with Records each year. The need for a firmly established rolling programme of review of the system and level of resources seems of paramount importance.

It would be valuable if Educational Psychology services could estimate the number of new children/young people each year with Records of Needs which include speech & language therapy needs, in order to develop some kind of 'formula' upon which an annual review of funding for the purchase of speech & language therapy services might be based. The present study revealed that the record-keeping procedures of educational psychologists are currently not well adapted to this type of task. Speech & language therapy needs are often only documented if they are the primary cause of referral, and otherwise can only be tracked by manual search of individual case-history files. More effective and efficient use of information technology would be helpful here. Statements on the level and type of therapy need in Records of Need are often completed by SLTs, rather than jointly negotiated. In order to ensure that speech & language therapy is as closely integrated as possible with education, collaboration at this stage in the Recording process would obviously be beneficial.

To allow education authorities to contract for speech & language therapy services at an appropriate level, the new councils commencing their administration in April 1996 will have to make the necessary funding available within the education budget. Guidance from the Scottish Office would be of benefit in safeguarding the system primed by the Secretary of State's (1991) Initiative.

Effective collaboration

The keys to enhancing the effectiveness of collaboration lie partly in the hands of individual SLTs, teachers and parents, partly in the hands of school management teams, and partly in the hands of the managers of the service purchaser and provider agencies. To bring about improvements, action needs to be taken at each of these levels, for they are inter-dependent.

Facilitating effective collaboration 'from the bottom up': individual SLTs, teachers and parents

At the level of individual teachers and SLTs, and of parents, facilitating effective collaboration would involve a loosening of personal and/or professional 'territoriality' and defensiveness; greater openness and sharing of expertise (along with a willingness to become a learner of others' skills as well as a specialist); and a willingness to take on board some of the goals of other team members. Some possible ways to bring about these aims would be: a reduction of the pressure of other work; more contact and communication with one another; more education about one another's roles, knowledge base and practice. Individual SLTs and teachers can provide a willingness to learn, and to use what they have learned in practice, but before this can happen, they are dependent on their managers for making available the necessary time and funding.

Facilitating effective collaboration: school-based agreements

A useful way for professionals and parents to ensure that the speech & language therapy service provided is what they want, and is effective in meeting needs, would be for the school and the individual SLT(s) who serve that school to discuss and negotiate realistic school-level service specifications. Such service specifications would include not only what is expected of the SLT but also what is expected of the school in terms of input to an integrated programme. Parents could specify their input to the programme if they wished to. The result would be a 'contract' or 'service agreement' between the school and SLT(s) which would form the basis of the service in the school, and at the same time provide a common frame of reference for all concerned, as well as a baseline for monitoring and evaluating the service. Such a contract should be formal to the extent that it is written up and agreed by all parties, although falling short of having 'legal' status. The service specification and contract should be reviewed each year, or more frequently if significant changes occurred (for example in membership of the service provision team).

Although the terms of the contract or service agreement might be very different across different schools, the agreement would need to be simple and sufficiently flexible. For example, they should not name specific pupils, or go into detail about specific work. They might not attempt to cover every single possible aspect of the working partnership but would probably make reference to areas which had been identified as problematical, and where guidelines would help. An appropriate level of detail might be as in the following hypothetical examples:

- At least half of the work per week (or per child) to be carried out in the classroom
- At least one hour timetabled per week, of each class teacher's time, for joint planning
- Teacher to provide draft of IEP (or other form of planning or report) for SLT's input one week in advance of deadline
- SLT to provide a copy of her timetable (including times of regular meetings, other clients treated, schools/clinics visited etc.) to each assistant head teacher/head of department
- School to provide SLT with a copy, each term, of all documents relating to curriculum development, in-service training sessions, dates of parents meetings etc.
- SLT, if taking holiday in term-time, to provide school with her holiday dates at least one month in advance[22]
- School to designate a 'link person' responsible for all official liaison with SLT

Such an agreement, as well as being useful in its own right, would necessitate a process of discussion which in itself would be valuable in clarifying and making explicit aspects of the work of both SLTs and teachers. Guidance and support in the process of drawing up such a contract, if necessary, might be available from educational psychologists, speech & language therapy managers and advisers in special educational needs, but these professionals should not be allowed to 'take over'. Only the school and the SLT(s) working there can really know what is appropriate and what can be delivered.

Facilitating effective collaboration 'from the top down'

At the level of line-managers (for example, speech & language therapy managers, education officers, special educational needs and other advisers, head teachers, principal educational psychologists), the aim would be to recognise and to try to remove or reduce the currently existing barriers to effective collaboration. A number of possible ways of doing this are discussed in subsequent sections, namely, giving staff members official permission to spend time for making contact, observing and sharing work, and joint staff development opportunities.

---

[22] The issue of SLTs taking annual leave during school terms, from the frequency with which the issue was raised during our surveys and interviews, appears to be a bone of contention among teachers, head teachers in particular, and therefore it may be appropriate for those involved in the drawing up of education contracts to tackle the issue at this level, rather than at the level of a school agreement.

It is at the level of service purchasers and providers that the most effective steps can be taken. When the contracts governing the provision of speech & language therapy services are drawn up between health and education (or indeed between any other potential purchasers and providers of speech & language therapy services), recognition has to be granted to the importance of the less direct and tangible aspects of therapy and education provision. Funding at a higher level than currently prevails may be required if service specifications are to include adequate time for education staff training, for all aspects of effective collaboration, and for a range of different ways of working (e.g. joint working, joint record keeping, group work, intensive blocks, skill sharing with staff and parents), as well as for provision of direct therapy at current levels. Purchasers and providers should recognise that both groups of professionals are likely to have to make adjustments, if the goal of effective collaboration is to be attained. To achieve this, purchasers and providers from both health and education need to collaborate amongst themselves.

Other ways and means to effective collaboration

There are several adaptations to the professional education of teachers and SLTs, and to day-to-day practices in schools and in classrooms, which could improve the way in which SLTs work within education. The onus cannot lie entirely with the speech & language therapy profession; there are implications too for the education professions. While there are some cost implications, in many cases these are relatively minor. In some cases, inter-agency collaboration will be required in order to determine how such costs might be shared across relevant agencies.

Many of the schools visited in the present study were implementing some or most of the conditions listed below, and the good practice observed suggests that such conditions do have a positive effect on collaboration in the education of pupils with special educational needs. The report of H. M. Inspectors of Schools: 'Effective Provision for Special Educational Needs', attributes to head teachers the responsibility to integrate specialist professional contributions into educational programmes by:

- Agreeing with each professional, arrangements to facilitate his or her work and that of the school;
- Providing information about the curriculum;
- Involving other professionals in the process of assessment, programme planning and evaluation;
- Ensuring that class teachers understand the roles of the specialists and the expectation of working together;
- Making time for class teachers and specialists to consult, with parents present when appropriate; and
- Making arrangements for school staff to be guided and trained by specialists, as required

(SOED, 1995: §4.26)

These principles should be more widely understood and accepted in schools, in particular in mainstream schools where effective communication among school staff and peripatetic specialists may be most difficult to achieve. In those schools visited where good collaborative practice had been established, the head teacher or other senior staff were shouldering at least some of these responsibilities, and explicitly agreed arrangements had been made. These principles, and issues arising from their implementation (or lack of it), will surface at points throughout the following sections.

The effectiveness of SLTs in the education of pupils with special educational needs would be enhanced if the following issues were addressed.

Education and training issues

1. **Increased input on speech, language and communication, and on the knowledge and skills of SLTs, should be included in teachers' pre- and post-qualification education and professional development programmes.**

In teachers' pre-qualification education, revised modules on language development would be beneficial, together with published literature for teachers on language development, the role of SLTs, and how speech & language therapy can be integrated with the curriculum. SLTs, dual-qualified SLTs/teachers and other experts could make a valuable contribution to such developments. Education authorities may have to request changes in the education of teachers if such developments are to be provided by Scottish teacher education institutions.

At post-graduate level, for example, the School of Education at Birmingham University has promoted the education of teachers in speech and language development, and in the most effective ways of working with SLTs, through the provision of distance-learning programmes open to both teachers and SLTs.

Currently, a few committed teachers and SLTs, in addition to their school-based work, present and publish thought-provoking and informative conference papers and articles for both teachers and SLTs, on aspects of speech & language therapy in education.

2. **Increased input on educational philosophies and curricula, and on policies and practices in relation to education authorities, schools and teachers, should be included in SLTs' initial and post-graduate education and professional development programmes.**

SLTs need to know about education, schools and working with pupils in schools, and access to such knowledge needs to be improved. An understanding of the role of speech & language therapy in education may be fostered early in the career of a SLT if more clinical placements with SLTs working in mainstream schools, as well as in special educational facilities, were available to student SLTs. These would enable better understanding of working with pupils in schools, of team working and of skill sharing. Hospital, clinic or special unit based placements, which emphasise the 'medical' face of speech & language therapy, may do little to prepare SLTs for work in education.

3. **An increase in the input made by SLTs to teachers' professional development programmes at a local level would be of benefit.**

The speech & language therapy profession's service guidelines state that offering in-service training is considered an integral part of the work of SLTs in mainstream schools and in special educational facilities.

> "[In mainstream schools, speech & language therapy] intervention will normally include the provision of in-service training to all staff involved with the child, on both a formal and informal basis."
>
> "[In special schools] intervention may include the therapist participating in workshops and staff training."
>
> "[In language units] the speech & language therapist should seek to include in-service training of education staff as part of intervention."

(CSLT, 1991: pp. 61, 64 & 68 respectively)

Many of the teachers who participated in the present project commented that they would like more in-service education from SLTs. Nearly half of our sample of 818 teachers indicated that they thought that more training for teachers about speech, language and communication would benefit pupils, and a substantial proportion of these classed this as a priority. Teachers wanted to know more about the role of the SLT and about a wide range of other topics:

> *"It would be useful to know what 'modern' SLTs have to offer, so we know what support we can ask for."*
>
> (Teacher in a special unit for pupils with emotional and behavioural problems)

> *"I would like more information on particular speech disorders and how therapists deal with them. For example, examples of programmes used."*
>
> (Nursery teacher)

It would be helpful for teachers to observe SLTs working with pupils. Less than a quarter of the teachers surveyed reported that they had observed a SLT doing this. It would also be valuable if some in-service sessions could be open to parents, or repeated for evening parent/staff meetings, or school board meetings.

Our survey of advisers in special educational needs established that within the last two years, there had been in-service training for teachers in speech, language and communication in most of the Scottish education authorities. In two education authorities, where in-service training on speech, language and communication had not occurred, there was reported to be continuous informal liaison between SLTs and teachers working with pupils with speech, language and communication difficulties. Different professionals provided in-service sessions: local SLTs, advisers in special educational needs, teachers, and, occasionally, educational psychologists. Other speakers involved in-service sessions relating to pupils with speech, language and communication difficulties included staff from independent grant-maintained special schools; representatives of firms who supply communication aid technology; nursery advisers; doctors; and staff from teacher education institutions.

An adviser in special educational needs from one region commented:

> *"There has been an excellent and long-standing relationship with speech & language therapy within the authority and their staff have made contributions to the learning support staff training over the years, including e.g. video material of pupils, and a language assessment/checklist for learning support staff use."*

Some teachers surveyed and interviewed had little knowledge of speech & language development, and felt the SLT was their only access to information. However, SLTs cannot be entirely responsible for teachers' knowledge of speech, language and communication. Education authorities, schools and teachers have to take responsibility for teachers' knowledge of speech, language and communication. Education authorities and schools could enable teachers to participate in co-ordinated and nationally accredited programmes of education on speech, language and communication.

Although SLTs already contribute to professional development programmes for education staff, a higher level of input would be valuable. There is a recurring need for in-service training from SLTs, as pupils move into classes with different teachers, as new staff enter the profession, and as other staff changes occur within schools.

While individual SLTs are committed to the principle of providing in-service training to education staff, adequate time for preparation, delivery and follow-up of in-service training is not always allocated within negotiated contracts. It would be helpful if managers ensured that time for delivery of staff development programmes was included in speech & language therapy service contracts with education.

4. Introduction of input by educationalists, including class teachers, on curriculum and classroom practices, to staff development of SLTs at a local level would be of benefit.

SLTs find it difficult to acquire adequate knowledge of the curriculum, of how it is differentiated and delivered, and of related attainment targets and assessment procedures. Access to documentation, opportunities to observe in classrooms and attend in-service training, would be beneficial.

Policy and curriculum development documents are not routinely circulated to SLTs as they are to all education staff. Some SLTs can have sight of documents but this requires awareness of their existence. It would be helpful if education authorities and head teachers made arrangements for SLTs working in schools to have notification of, and access to, SOED and education authority policy documents. SLTs could receive copies of relevant documents; however, in practice, the sheer volume of documentation would pose a serious barrier for individual SLTs, especially in light of the considerable volume of NHS briefings SLTs are already obliged to assimilate. Ideally, what is required is a system whereby SLTs receive regular briefings on new developments from a designated member of education staff and gain access to documents on request.

There appears to be no straightforward solution to this documentation problem. The HMI Report on effective provision for special educational needs (SOED, 1995) suggests that it is the responsibility of head teachers to provide information on the curriculum. While this makes sense in terms of management responsibilities, it may not be entirely practical for individual head teachers to communicate to individual SLTs information about national or authority-wide curriculum developments, particularly since most SLTs working in education cover several schools. Other possibilities include the assumption, by advisers in special educational needs, specialist teachers or heads of learning support, of responsibility for the communication to SLTs of educational policy. Different arrangements may be appropriate in different settings. However, managers of speech & language therapy services and education authorities need to find local solutions, and central guidance from SOED may be needed to pave the way.

A direct way for SLTs to learn about what goes on in classrooms is for them to sit in and observe classroom work. A valuable method, particularly in the context of secondary pupils, is for SLTs to 'shadow' one or more of their clients, observing them in different classes in order to gain an understanding of how different teachers work, and of what particular difficulties speech, language and communication impaired pupils face in a range of contexts.

It would also be useful for SLTs to be able to attend in-service education on aspects of the curriculum as part of their own staff development programme. Sessions designed specifically for SLTs and delivered by educationalists would be valuable, as also would some in-service sessions designed for teachers.

5. At a local level, cross-budgeting or no-cost agreements between health and education would allow teachers and SLTs to attend some elements of each other's staff development jointly. It would also be beneficial if these were extended to include other education staff and parents.

This type of arrangement may occur informally in some areas. From our survey of advisers in special educational needs, it is clear that a range of education staff attend in-service training organised by education on aspects of speech, language and communication. Usually class teachers, learning support teachers and special educational needs teachers attend sessions and, in some regions, head teachers and members of school management teams. In three regions, special needs/classroom auxiliaries also attended sessions, but one adviser noted that this was 'in their own time.' Only in one region were in-service sessions open to parents, carers and nursery nurses. One adviser in special educational needs mentioned courses run by the suppliers of communication aid technology, and pointed out:

"Since communication technology is used at a significant level it is important that teaching staff, SLTs and parents are familiar with the equipment and have shared aims for the children."

Seven of the advisers in special educational needs surveyed reported that SLTs could attend in-service training organised by education, alongside their teacher colleagues, but the advisers did not know if SLTs had ever attended sessions. Most advisers said they did not know if it were possible for SLTs to attend sessions, and one commented that questions might be raised as to who would fund their attendance.

6. **At a local level, there is a need for improved planning and notification of relevant staff development opportunities and in-service courses for SLTs and teachers.**

If SLTs are to attend in-service courses organised by education, a system of information sharing would have to be developed which notified them in enough time for them to timetable their attendance. This may require a change in attitude as well as a change in administrative arrangements on the part of education authorities and schools.

Similarly, arrangements may need to be made to facilitate education staff attending relevant staff development activities organised by speech & language therapy departments.

7. **Provision of supply cover for teachers and relevant auxiliary staff and flexibility over reprogramming of speech & language therapy would ensure that practical support is given to allow staff to attend in-service courses.**

Our interviews revealed that teachers and SLTs are aware of some in-service training opportunities, and that many SLTs, teachers and auxiliary staff pay their own attendance fees and travel costs, in order to attend courses and meetings in their own time. However, even if staff meet the costs of attending a course or meeting, they are sometimes prevented from going because no classroom cover can be provided to allow them to leave school. On other occasions, we were told that only one member of a team was allowed to go and was expected to relay the information back to the others, which may not be the most effective way for a team to operate. If speech, language and communication is to be treated as a high priority area in education, it would be an efficient use of resources for SLTs and education staff to attend jointly in-service sessions on this topic.

8. **It needs to be recognises at a local and school level that auxiliary staff are extremely important members of the team working with pupils with speech, language and communication difficulties.**

Classroom auxiliaries, special educational needs assistants, speech & language therapy assistants and, in some cases, classroom volunteers, also require access to relevant staff development opportunities and in-service courses on speech, language and communication, along with the teachers and SLTs with whom they work. They should not be left behind to 'mind' the class, as seems to happen routinely in some settings. Apart from depriving them of staff development opportunities, which would be of benefit to them, to the pupils and to the other staff with whom they work, this model undermines the principles of effective collaboration and teamwork, where mutual respect and appreciation are essential.

Teamwork issues

9. **Joint assessment, goal setting and planning of children's programmes of work are essential components of effective collaboration.**

Crucial to the process of collaborative working is the issue of joint planning of programmes of speech & language therapy and education. Different schools have different frameworks, although all will be founded on the 5–14 Guidelines, Individual Educational Programme development, and the Record of Needs procedures. In order to fully participate in joint planning, SLTs need to learn how all of these work. They also need to become familiar with each pupil's educational programme and current attainment targets. SLTs will also need guidance from teachers on how the aims and methods of speech & language therapy might be integrated into these. Teachers are likely to benefit from the specialised focus that the SLT's analysis of each pupil's programme brings, and from the introduction, by the SLT, of assessment schedules, language programmes and specialised materials that may be incorporated into the classroom programme. As well as planning and implementing integrated programmes of speech & language therapy and education, it is also important for teachers and SLTs to evaluate the programmes they are delivering.

10. More time officially needs to be timetabled for liaison among SLTs, teachers and other education staff.

SLTs may work closely with teachers and auxiliaries in the classroom, delivering speech & language therapy and education in an integrated way. The joint planning and monitoring required for this work cannot easily be 'squeezed into' five minutes here and there over coffee and lunch breaks. Special facilitative arrangements are needed. In addition, the time required to carry out this liaison needs to be reflected in the contracts which speech & language therapy managers draw up with education authorities, and should also feature in school-level agreements between SLTs and head teachers.

> "The most effective use is made of members of support services, such as educational psychologists and therapists, when the nature and aims of their work are understood and fully integrated into the educational programmes of individual pupils or students. Senior staff have to ensure that time is set aside to enable teachers and members of support services to meet regularly to exchange information, plan and review their work."
>
> (SOED, 1995: §2.18)

Visiting schools and units, we found a wide range of time allocations among teachers for discussion, liaison, joint planning and preparation with SLTs. The range went from no time to one day per week. In an extended learning support (ELS) facility one day per week was available to the ELS specialist teacher for liaison with class teachers, discussion and planning with the SLT, Record of Needs review meetings and other meetings; a 0.2 WTE class teacher was brought in to cover classes so that teachers could liaise with the ELS teacher. In other settings a shorter time period may be adequate for liaison but a regular minimum time period should be set for liaison between SLTs and teachers where there are pupils with severe and persisting speech, language and communication difficulties.

As well as their role in providing information and feedback for teachers, SLTs may need to recognise the value of equal partnership in their collaborative work with teachers; the balance may need to shift away from the SLT as the 'expert' towards SLT and teacher as partners in the joint planning of educational and therapeutic programmes. While SLTs appear to consider collaboration an important and essential part of their work in schools, our survey results suggest that some SLTs had little experience of joint planning of programmes, and that this was particularly the case in mainstream settings. Who is the best collaborative partner for a SLT if appropriate support and educational programmes are to be provided for pupils with speech, language and communication difficulties in mainstream schools? We shall return to this issue later in this chapter.

Teacher/SLT teams should also attempt to establish short but regular discussion meetings with head teachers or assistant head teachers. In part, this may ensure that the school management is informed of, and involved in, the work of the teacher/SLT team and may protect teachers and SLTs from trying to solve every problem at classroom level. Many of the problems experienced by classroom teachers and auxiliaries and reported to us on our visits could probably be solved with the goodwill and support of a senior member of staff. On our visits, we discovered to our surprise that one common reason why no time had been scheduled for liaison between SLT and education staff was that nobody had ever asked for it! Teachers who had asked their head of service for liaison time, and were able to make a cogent case for the benefit of such work, generally seemed to be successful in acquiring it.

Record keeping issues

11. Speech & language therapy record keeping procedures, and the reports written by SLTs, should be integrated into school and Record of Needs recording procedures.

Integrated record keeping would save time and effort and avoid alienating school staff with 'secret files locked in the medical room cabinet'.

In one special school we visited, the SLT described a simple, practical and integrated system of goal setting, interdisciplinary communication and record keeping, which prevented unnecessary duplication of effort. The SLT kept a file in the classroom for each pupil, and this was open for all to read and to write things into. The file included aims, things that were being targeted, and little 'reports' on what work had been done recently by the SLT. The teacher might write her classroom notes in there, too, or might just scribble 'see child's file'. At the end of the term, these pages were photocopied and put into the SLT's notes. As the SLT involved commented:

> *"We find it's good to be open."*

However, sharing information raises issues of confidentiality and these would need to be resolved and agreed by all concerned.

Team building issues

12. In individual schools, head teachers need to take steps to ensure that the SLT is 'part of the school'.

The difficulties of being an 'outsider', in a tightly hierarchical institution like a school, are legendary. They can be summed up, and will be instantly recognisable to all 'outsiders', by the following tale:

> "June Saunders, the visiting physiotherapist at Queensway Infant School was disliked by many of the staff because at break time she used any clean mug for her coffee and she sat in a different seat each week. All the staff had their own mug and always sat in the same chair in the staffroom. No one said anything to June, in fact they avoided engaging in conversation with her. The staff expected her to realise the procedures in their staffroom – thinking that such procedures were common to all schools."
>
> (Lacey & Lomas, 1993: p. 49)

With this sort of backdrop, it is unlikely that SLTs and teachers can work together effectively. Small changes can make a significant difference. In one large secondary school we visited, teachers were unsure about how often the SLT visited the school, which days and times she was in the school, and how and where they might be able to contact her. Within the school all the teachers had a 'pigeon hole', and this was the way most messages were passed, but the SLT did *not* have a pigeon hole. This school also used a system of large 'notice boards' for the display of relevant information; although information about visits from learning support specialists and peripatetic subject teachers was prominently displayed here, there was nothing about speech & language therapy. Although an assistant head teacher had the SLT's timetable, as did a few other staff with whom the SLT already worked, copies of this had not been passed to other members of staff nor was it displayed on a notice board anywhere.

Schools may need to conduct a structural review in order to identify ways in which the school could be made more accommodating to visiting SLTs (and to other visiting professionals).

13. Involvement of school(s) in the recruitment and appointment of new members of SLT staff would facilitate selection of individuals who would fit well into the school(s) concerned and work in partnership with education staff.

That schools should be involved with the recruitment of SLTs was suggested in interviews by two different professionals from different regions, one from an education background and one from a speech & language therapy background, both with a high level of responsibility for management. When a new SLT was about to join an educational team, this would be a good time to review the requirements of the whole team and the factors influencing effective team working, thereby to arrive at a profile of a new SLT's personal and professional qualities desired by the team. Interdisciplinary consultation may take place at many different levels and may take many forms, from consultation over the wording of the job description and advertisement to the full participation of education staff as members of an interview panel.

In one region the speech & language therapy manager reported that a head teacher and a parent were included on the interview panel of SLTs applying to work in posts involving significant amounts of school-based work. The head teacher generally preferred a different applicant to the one preferred by the speech & language therapy manager, and the difference could be quite marked, sometimes to the extent that the entire 'order of preference' of candidates was completely reversed. The speech & language therapy manager thought that this occurred because speech & language therapy managers, knowing that life is hard for SLTs 'out there' in schools, tend to go for applicants who show the maximum resourcefulness and resilience, in other words, they pick people perceived as 'leaders'. Head teachers, knowing that schools already have to contend with the professional autonomy of SLTs, try to balance this by choosing more compliant personality types, who indicate an ability to be flexible and 'fit in', people more likely to be 'followers'.

14. Involvement of speech & language therapy staff in the recruitment and appointment of new members of staff of special educational facilities catering for pupils with speech, language and communication difficulties, would facilitate selection of individuals who would work in partnership with SLTs.

If the previous point is a valid one, then we ought to look at its mirror image. Where the education post in question is a key one in a special unit or class for pupils with specific language disorder, it would be helpful if speech & language therapy managers and/or school based SLTs were invited to collaborate with schools and education authorities as early as possible in the process of recruiting: in specifying job descriptions, wording job advertisements, and appraising possible applicants. Our interviews suggested that senior SLTs or speech & language therapy managers are already often included on interview panels for language units. It seems that, in a potential language unit teacher, SLTs seek evidence of a knowledge base in the language development process, and in special aspects of cognitive and linguistic processing, rather than a particular personality type.

15 Teachers, SLTs and classroom assistants would benefit from better mutual understanding of each other's conditions of service.

While the view that SLTs should continue to be employed by health may be fairly general (see Chapter 5), there is little doubt that the differences between the conditions of service of SLTs and teachers contribute to mutual misunderstanding of each other's roles. Teachers work shorter hours and get longer holidays than SLTs, and have nonteaching time set aside officially for staff development. But while they are in school, they tend to be very firmly tied to the classroom. Any absence from the classroom, for study leave or in-service, has to be negotiated and agreed with the head teacher and can be difficult to obtain. Also, teachers often work at home in the evenings and attend in-service staff development courses in their own time.

Although they tend to work longer hours each day, SLTs work much more autonomously, which can seem enviable to teachers. They may take their holidays (25 – 30 days maximum per year, in comparison with teachers' 65 days) whenever they choose, although many SLTs working in schools choose to take their annual leave during school holiday times, and some speech & language therapy mangers discourage their staff from taking annual leave during school terms. They can structure their days as they choose, to some extent, and may tend to do so with the aim of maximum efficiency, rather than with the aim of conforming to someone else's institutional traditions. SLTs may also treat adult clients after the end of the school day or in the evening. In addition, they make regular home visits to parents and often run 'summer schools' or blocks of intensive therapy during the school holidays. SLTs may be responsible for a large caseload of clients across a wide geographical area and many have to fit in considerable amounts of travel each week. They also have to fit in meetings with their own professional managers and colleagues, as well as case conferences and review meetings for clients, alongside training of other staff, collaboration and direct and indirect therapy commitments.

Classroom special needs auxiliaries have significantly lower pay than both teachers and SLTs, although we have come across cases where people employed as auxiliaries were actually fully qualified teachers, nursery nurses, or, in one case, a SLT. Auxiliaries are very firmly at the lower end of the 'pecking order' in schools. They are considered to work at all times under very tight supervision from teachers. In practice, there can be wide variation in the degree of autonomy exercised by classroom auxiliaries, depending on a number of factors, such as the time available to the teacher to exercise constructive management, the experience and confidence of the teacher, the experience and confidence of the auxiliary, and the length of time a teacher-auxiliary 'team' has been working together. Auxiliaries tend to be employed only for the exact hours the pupils are physically present in schools. This means that any work they are required to do, or wish to do from their own sense of professional commitment, such as collaboration with teachers and SLTs, discussion, joint planning, and preparation of materials, has to be done in their own, unpaid time. It can sometimes be very difficult indeed for classroom/special educational needs auxiliaries to obtain agreement from head teachers for release from the classroom in order to attend specialist in-service training in speech, language and communication along with their teacher and SLT team-mates. In one region we visited, we learned that a new training course for special educational needs auxiliaries had been set up at a local further education institution. New applicants for auxiliary jobs who had this training were preferred over unqualified applicants, but existing auxiliaries already in employment with the region were not released or supported in order to attend the course. Those completing the course and gaining the SVQ (Scottish Vocational Qualification) were not entitled to any higher grading than untrained staff.

A similar lack of career structure applies to speech & language therapy assistants (of whom there seem to be very few working in education in Scotland). A new S/NVQ Scottish/National Vocational Qualification) has recently been piloted at 13 sites in the UK and is on target for formal approval by the Scottish Vocational Education Council (SCOTVEC) and the National Council for Vocational Qualifications (NCVQ) during 1996. Speech & language therapy assistants have little in the way of a professional 'peer group', which may leave them uncertain of their role.

Developments in the curriculum

Although the 5–14 curriculum provides the foundation for a shared common framework for SLTs and teachers, there are problems, particularly at Level A, which need to be addressed:

> *"Listening and Talking strands at Level A are too insubstantial to be much use."*
>
> (Language support teacher)

The teacher from whom the above quote is taken also reported difficulty in planning a programme of work under separate outcomes. Many of the areas targeted by SLTs and specialist teachers cross the four outcomes of listening, talking, reading and writing; for example, phonological awareness skills appear to be important to all four outcomes. Yet for the 5–14 curriculum as currently conceived, outcomes can only be classified under either oracy or literacy skills.

In our interviews, teachers of pupils with severe/profound/complex learning difficulties reported that it was depressing for both staff and parents that pupils might be working towards (and might never achieve) the Level A targets. The need for a more detailed and differentiated set of targets, in particular for Level A, appears to be a pressing need for many pupils with special educational needs and the staff who are working with them. While some of this work is already under way (see, for example, SOED, 1993), the needs of pupils with speech, language and communication difficulties should be addressed more specifically. National guidelines in this area would be of great benefit, and SLTs and specialist language support teachers might usefully contribute to a collaborative project which sought to establish more relevant and detailed targets for pupils with speech, language and communication difficulties.

Educational support for pupils with speech, language & communication difficulties

In addition to protecting, and where possible enhancing the provision of speech & language therapy, education authorities could find ways of ensuring that the input from SLTs is as well supported and integrated into the classroom as possible. This is a particularly pressing issue in the case of pupils with speech, language and communication difficulties in mainstream settings. In the words of one SLT working with pupils with Records of Needs:

> *"Slow progress for children in mainstream schools as most have inadequate support in school – the class teachers working on goals as they are able. Progress is a lot slower than it need be e.g. if there was an auxiliary available to work daily on a programme with that child progress would be greatly enhanced."*

There is a degree of consensus across both teachers and SLTs that mainstream class teachers are rarely in the position to provide regular, individual support to pupils unless they have extra help to do so. Below we outline a range of possibilities which may be investigated in order to arrive at a system within which extra support is organised for pupils with speech, language and communication difficulties and which is relevant and appropriate to local circumstances.

A relatively small number of teachers in Scotland have acquired special experience, knowledge and skills with pupils with speech, language and communication difficulties, and some of these teachers have had access to advanced training or qualifications in the area of speech, language and communication. These include peripatetic language support teachers, teachers working in language units, teachers working with users of augmentative and alternative communication systems and teachers of the deaf.

Language support teachers

Peripatetic language support teachers may provide the necessary bridge between individual educational programmes which target aspects of speech, language and communication and the curricular programmes of a mainstream class. The varied pressures and constraints within which a mainstream class teacher has to operate may militate against the degree of collaboration required for the successful implementation of an individual programme, such as at Level II or Level III of the model of needs presented in Chapter 5. SLTs and language support teachers working together on joint planning and implementation of programmes are more likely to overcome the difficulties in dovetailing speech, language and communication needs into the framework of a class curriculum, such as experienced by the SLT quoted on page 76.

As a result of our visits, we can outline some of the systems within which peripatetic language support is currently organised. In one arrangement, peripatetic language support is provided by members of staff of a language unit. These teachers work either partly or entirely in mainstream, providing 'outreach' support, either to pupils who have been re-integrated to mainstream following a spell in a language unit/class, or to other pupils. (Macdonald, 1994, describes one example of this kind of arrangement.). Advantages include the availability of a central resource of materials and staff, which will include at least one specialist SLT, and therefore a bank of expertise which is focused on the provision of support at a variety of levels for pupils in an educational context. Since a language unit/class is a 'physical' resource, it is also available for observation and placement for staff in professional development programmes.

In another location, language support teachers are members of a learning support team; in the particular case from which our interview data are drawn, they were learning support teachers who had undertaken a course of further study on speech & language difficulties in children. These peripatetic teachers spent a proportion of their time supporting pupils with speech, language and communication difficulties in mainstream schools and the rest of their time in generic learning support. Their responsibility was to provide support for pupils, usually in the classroom setting, but also using withdrawal from the class where appropriate, in order to ensure a pupil had the knowledge and skills to access the class curriculum, or was provided with a differentiated or individual programme in areas where the class programme was not appropriate. These teachers were attempting to bridge the gap between speech & language therapy and education, and to provide a more integrated programme than had been possible in the past. This arrangement also has strengths, in particular in its potential for flexibility, where numbers of pupils requiring language support may vary from year to year. The interface between SLTs and language support teachers in this situation may present difficulties, particularly where SLTs are community-based, have large caseloads and work across a variety of health and other settings as well as in schools. In order for it to work well, there needs to be a system whereby SLTs and language support teachers have easy, regular and timetabled access to each other, to build up a working relationship and to establish the shared understanding that is required for joint planning and implementation of speech, language and communication programmes and the integration of appropriate speech, language and communication targets into individual educational programmes. SLTs working in mainstream schools may need membership, in some form, of learning support teams for this to be facilitated.

Learning support teachers

The learning support teachers interviewed during our visits to schools, with one or two exceptions, had relatively little contact with SLTs, and rarely viewed their role as overlapping with that of the SLT. (For one notable exception, see the description of the central role of the learning support teacher in the description of innovative practice in a mainstream primary school in Chapter 4: case study A.) This was in marked contrast to the views of language support teachers interviewed who were likely to view their work and that of the SLT as covering largely the same ground, but perhaps with a different focus.

It is the view of this research team that, in many respects, a learning support teacher is a much more 'natural' collaborative partner for a SLT than is a mainstream class teacher. A learning support teacher is more likely to employ diagnostic techniques than a class teacher; she is more likely to see her role with a particular pupil as short-term or intermittent; and she may also have far more sensitivity than a class teacher to the problems arising from being peripatetic and from being answerable to 'different masters' (i.e. individual head teachers and the head of the learning support team). While SLTs may appear as 'outsiders' because they are not directly employed by education, in practice, their way of working is very similar to that of a learning support teacher. The single biggest difference for a community-based SLT is likely to be in the larger size of her caseload compared to the number of pupils for whom an individual learning support teacher has responsibility. For SLTs who are paediatric/special needs specialists, or whose remit is relatively more constrained to pupils with Records of Needs, this 'caseload differential' may be considerably smaller. It seems that the collaborative potential of learning support teachers and SLTs may be under-exploited at present; consideration should be given to expanding the role of learning support teachers to include some responsibility for supporting speech, language and communication needs in mainstream classes. If this system is to be adopted, re-assessment of learning support staffing needs may be required, as well as the need for relevant professional development opportunities and integration of SLTs working in schools covered by individual learning support teams. Specialist language support teachers could be included as part of this arrangement, in order to cater for pupils with very severe or complex speech, language and communication needs.

Classroom assistants

Given the findings from our survey of SLTs suggesting the important role of classroom auxiliaries/assistants in the continuation of speech & language therapy programmes, a further possibility would involve the employment of extra classroom assistants, who would have a special responsibility for the support of speech, language and communication work throughout the school day. A possible model is one where the assistant works to the SLT *programme* (as opposed to the SLT in person) and to the *curriculum* (as opposed to just being an extra pair of hands for the class teacher). This might be a powerful motivation for bringing SLTs, learning support, special educational needs and class teachers together for joint planning, delivery and evaluation of programmes.

Employment by education of classroom assistants seems a better option than the employment of speech & language therapy assistants for a number of reasons. Firstly, it is a much more straightforward 'in-house' educational operation, and would not necessitate any contracting or transfer of funds. It would obviate the risk of funding designated for speech & language therapy services being diverted into 'cheaper' services. It is probable that the 'familiar' person of a classroom assistant, albeit with a new and special role, would be much more easily assimilated into the classroom/school culture than an unfamiliar breed of staff member (i.e. a speech & language therapy assistant) from 'outside'. Moreover, SLTs are often so hard-pressed for time that it is sometimes difficult, except in large departments, to find enough time for planning and supervising the work of assistants. Such staff might, therefore, on occasion, be under-employed, since there are relatively few schools in which the SLT would be present all the time to supervise the work of speech & language assistants. An education-based assistant, on the other hand, might be usefully deployed by teachers, while still carrying through the aims and principles of her work on speech, language and communication programmes. Finally, expanding the role of speech & language therapy assistants could be counter-productive in that it might reinforce the perception of speech, language and communication as entirely the responsibility of the speech & language therapy profession, rather than as a responsibility which is shared with education staff.

The work of defining and developing the role of a new category of classroom assistant could provide a focus for a short-term joint project, on a 'commissioned' basis, between SLT services and education, possibly at Scottish Office level rather than at the level of many different education authorities. The grading, education, role and chain of accountability/line management of new assistants would of course need to be very carefully considered. The proposed role would need to be supported with special training and this would need to be reflected in a higher grading and salary. Classroom assistants with a special responsibility for speech, language and communication could help to ensure a more integrated service between speech & language therapy and education.

Support for pupils using augmentative & alternative communication (AAC) systems

The classroom or school where there are users of AAC systems is a special case. From our visits to both mainstream and special educational facilities attended by pupils using AAC systems, the extra workload involved with pupils of this sort was so striking that, in our opinion, there is a strong argument for the employment of speech & language therapy assistants ***and*** additional classroom assistants, as well as for higher than average teacher and SLT staffing levels. This applies particularly where there is a high concentration of AAC users, but also where there are one or two 'isolated' AAC users needing special support, such as might be required by secondary pupils studying foreign languages or subjects which demand a large technical vocabulary.

Support for pupils with hearing impairment

Teachers of the deaf appear to vary in the degree to which they view their role as overlapping that of the SLT. Those we interviewed were more likely than, for example, language support teachers or teachers in other special educational facilities, to present a 'demarcationist' case, in which they presented themselves as having primary responsibility for the more central aspects of language, communication and the curriculum, and the SLT as having a role only in constrained areas such as auditory training, and work on pronunciation, intonation and other aspects of 'speech'. However, in one special facility for deaf pupils, joint planning of both class and individual educational programmes and speech & language therapy programmes was a pivotal part of the collaborative practice between assistant head teacher and SLT; this way of working was a source of satisfaction to both parties. The lack of true partnership in working with pupils with hearing impairment, and the defensive or isolationist attitudes of many teachers of the deaf, was a source of extreme frustration to some teachers (including some teachers of the deaf) and SLTs we interviewed. It would appear that there are still many historical barriers to be overcome between teachers of the deaf, other teachers working with pupils with hearing impairment and SLTs. Not only is generalised collaborative practice not yet achieved, but also there is as yet no real consensus that it is required. It is beyond the scope of this project to provide further illumination of this problem, but it is one that, in our view, requires attention.

Advancing the professional development of teachers and SLTs working with pupils with speech, language and communication difficulties

Both education staff and SLTs would benefit from education in each other's field of knowledge. One of the most urgent needs is that of teachers for knowledge of the development and disorders of speech, language and communication. As Miller (1992: p. 90) writes:

> "Recent developments in the school curriculum lay specific emphasis on language skills so that a detailed knowledge of language is valuable for all teachers: communication is now an explicit part of every curriculum area. Where there are children with particular language needs, teachers must be able to describe these and discuss with colleagues how they can be met in the classroom. Teachers therefore need a language to talk about language. They need to be clear about the particular

> language skills required of children in any activity and they need to be aware of the central importance of their own language skills in communicating effectively with children at varying levels of ability. In a recent survey of teachers working with children with speech and language disorders, teachers additionally expressed the need to know how to manage the children in the classroom and how to talk about speech and language impairment with parents and with other professionals."

There are few available education opportunities of the necessary depth. The current pattern of fragmentation of post-qualification training in special educational needs into 'self-supported study' modules will not help the situation. Language is an abstract and complex topic which does not lend itself particularly well to the one-day, practically orientated workshop which is becoming the norm for school-based professional development.

Miller (1995) proposed a set of core competencies required by teachers working with pupils with speech, language and communication difficulties. The competencies were based on the views of a working group of SLTs, which were subsequently modified by the responses of teachers (who were past students who had completed a distance learning course on speech & language difficulties run by Birmingham University). Miller proposed that teachers should be able to ***do*** the following:

1. Make observations which reflect knowledge and understanding of the processes of communication and language within the overall development of children
2. Recognise the nature of communication and language difficulties and their effects on children's learning
3. Plan, implement and evaluate the curriculum taking into account the needs of children with communication and language difficulties
4. Participate in and evaluate inter-professional intervention with children with communication and language difficulties
5. Reflect on their own spoken and written communication skills with children and their parents and with colleagues
6. Reflect on their own teaching practice and describe any changes they have made as a result of their study

The distance learning course on speech & language difficulties at Birmingham University mentioned above has since expanded its intake to SLTs, and has a policy of encouraging the joint attendance of teachers and SLTs who work together. This is an explicit recognition of the importance of shared knowledge in fostering effective collaborative partnerships.

It would appear that more opportunities are also becoming available for teachers in Scotland to participate in courses which deal specifically with speech, language and communication difficulties and which are available locally. The above list of competencies may serve as a useful baseline for the setting of aims and objectives of such courses. It would also be beneficial if these courses could be adapted to encourage joint attendance by SLT/teacher colleagues, and if this were actively supported by both health and education management. We believe, from the findings of the present study, that SLTs in Scotland will welcome the advent of such courses. They will be keen to be involved themselves and to work with colleagues from other disciplines involved in such courses. Not least, they will see such courses as part of a long overdue recognition of the fact that meeting the needs of pupils with special educational needs who have speech, language and communication difficulties is the shared responsibility of both speech & language therapy *and* education.

Summary and conclusions

This chapter has focused on the implications of the findings of this study for future policy and practice. It has outlined a range of possible routes to the maintenance and improvement of educational provision for pupils with speech, language and communication difficulties, both from the 'top down' and from the 'bottom up', through speech & language therapy services to schools and through other types of educational support for pupils in schools.

Discussion of whether more overall resources are required for speech & language therapy services in education highlighted the need for:

- Scientific studies of the efficacy of speech & language therapy, in particular, studies which take into account outcomes in educational terms, such as improved access to the curriculum, or more appropriate individualised educational programmes
- Development of objective methods for identifying and comparing 'need' for speech & language therapy across different speech & language therapy client groups
- Investigation of the cost-effectiveness of different methods of delivery of speech & language therapy services.

It was suggested that there was a need for mechanisms for ongoing review of funding levels in the light of the numbers of pupils with Records of Needs who have a specified requirement for speech & language therapy services.

The chapter also examined implications of the study findings for collaborative practice and proposed some possible actions by which the effectiveness of collaboration among SLTs, education staff and parents might be enhanced. These included measures which might be undertaken by individual members of staff, by head teachers, by managers, by education authorities, by providers of speech & language therapy services and by policy makers.

In examining the need both for collaborative partners for SLTs and for educational support for pupils with speech, language and communication difficulties, the chapter explored the roles of specialist language support teachers, of learning support teachers and of classroom assistants. Implications of the study in respect of future developments in the 5–14 Curriculum were also considered. The chapter concluded with discussion of how professional development, particularly of teachers, may be advanced to provide 'core competencies' for working with pupils who have speech, language and communication difficulties.

References

Allan, J., Brown, S. and Munn, P. (1991) *Off the Record: Mainstream Provision for Pupils with Non-recorded Learning Difficulties in Primary and Secondary Schools.* Edinburgh: Scottish Council for Research in Education.

Anderson, H., Constable, A. and Graham, F. (1990) Teacher training by speech therapists: a report on a joint funded project (Hounslow & Spelthorne Health Authority and Hounslow Education Authority Oct. 1989–April 1990). In J. Wright and M. Kersner (Eds.) *Working together for children with communication problems: proceedings of a study day.* London: NHCSS.

Bishop, D. and Adams, C. (1990) A prospective study of the relationship between specific language impairment, phonological disorders and reading retardation. *Journal of Child Psychology and Psychiatry*, **31**, 1027-50.

Bryan, K., Maxim, J., McIntosh, J., McClelland, A., Wirz, S., Edmundson, A. and Snowling, M. (1991) The facts behind the figures: a reply to Enderby and Davies (1989). *British Journal of Disorders of Communication*, **26**, 253-261.

College of Speech & Language Therapists (1991) *Communicating Quality: Professional Standards for speech and Language Therapists.* London: CSLT.

College of Speech & Language Therapists (1993) *Audit: a Manual for Speech and Language Therapists.* London: CSLT.

Committee of Enquiry into the Education of Handicapped Children and Young People (1978) *Special Educational Needs: Report of the Committee of Enquiry into the Education of Handicapped Children and Young People, chaired by H.M. Warnock.* London: HMSO.

Committee of Enquiry into the Speech Therapy Services (1972) *Speech Therapy Services: Report of the Committee of Enquiry, chaired by Randolph Quirk.* London: HMSO.

Daines, B. (1992) Crossing the divide: the relationship between teaching in class and speech and language therapy programme objectives. In C. Miller (Ed.) *The Education System and Speech Therapy.* London: AFASIC.

Drillien, C. and Drummond, M. (1983) *Development Screening and the Child with Special Needs.* London: Heinemann.

Enderby, P. and Davies, P. (1989) Communication disorders: planning a service to meet the needs. *British Journal of Disorders of Communication*, **24**, 301-331.

Enderby, P. and Philipp, R. (1986) Speech and language handicap: towards knowing the size of the problem. *British Journal of Disorders of Communication*, **21**, 151-165.

Gower, S. and Sisson, L. (1994) Exactly what do they do? *Special Children*(Nov/Dec 1994), 13-14.

ISD Scottish Health Service Common Service Agency (1995) NHSiS Speech Therapy Services 1994. *Health Briefing*, **95/07**(March).

Lacey, P. (1995) In the front line: special educational needs co-ordinators and liaison. *Support for Learning*, **10**(2), 57-62.

Lacey, P. and Lomas, L. (1993) *Support Services and the Curriculum: A Practical Guide to Collaboration*. London: David Fulton.

Macdonald, A. C. (1994) Support for language for language impaired children. In J. Watson (Ed.) *Meeting Special Educational Needs. Vol. 5: Working with Communication Difficulties*. Edinburgh: Moray House Institute of Education.

McIlhenney, F. (1990) *Curriculum for Special Needs: Structure and Balance in the Curriculum for Pupils with Severe and Profound Learning Difficulties*. Glasgow: Jordanhill College of Education.

Miller, C. (1992) Speech, language and the new curriculum. *British Journal of Special Education*, **19**, 71-73.

Miller, C. and Wright, J. (1995) Teachers of pupils with speech and language difficulties: outcomes of specialist courses. *Child Language Teaching and Therapy*, **11**, 308-318.

Scottish Education Department (1973) *The Training of Staff for Centres for the Mentally Handicapped: Report of the Melville Committee*. Edinburgh: HMSO.

Scottish Education Department (1978) *The Education of Pupils with Learning Difficulties in Primary and Secondary Schools in Scotland: A Report by H. M. Inspectors of Schools*. Edinburgh: HMSO.

Scottish Education Department (1989) *Curriculum and Assessment in Scotland: A Policy for the 90's (Working Paper no. 1)*. Edinburgh: SED.

Scottish Home and Health Department (1988) *Planning Effective Speech Therapy: report of a working group of the National Paramedical Consultative Committee*. Edinburgh: HMSO.

Scottish Office Education Department (1991) *The Parents' Charter in Scotland*. Edinburgh: HMSO.

Scottish Office Education Department (1992) *Circular to Directors of Education 24/6/92 (Ref. HLA00310.062)*.

Scottish Office Education Department (1993) *Curriculum and Assessment in Scotland: National Guidelines: the Structure and Balance of the Curriculum 5–14*. Edinburgh: The Scottish Office.

Scottish Office Education Department (1994) *Implementing 5-14: A Progress Report (Interchange no. 23)*. Edinburgh: SOED.

Scottish Office Education Department (1995) *Effective Provision for Special Educational Needs: A Report by H. M. Inspectors of Schools*. Edinburgh: SOED.

Scottish Office Home and Health Department (1993) *Speech and Language Therapy Provision for Children and Young People under 20: An Initial Report of a Working Group of the National Paramedical Advisory Committee*. Edinburgh: The Scottish Office.

Sheridan, M. (1973) Children of seven years with marked speech defects. *British Journal of Disorders of Communication*, **8**, 9-16.

Silva, P. A. (1987) Epidemiology, longitudinal course and some associated factors: an update. In W. Yule and M. Rutter (Eds.) *Language Development and Disorders*. Oxford: MacKeith Press/Blackwell.

Thomson, G. O. B., Stewart, M. E. and Ward, K. M. (1995) *Criteria for opening records of needs*. Edinburgh: SOED.

Tomlinson, S. (1982) *A Sociology of Special Education*. London: Routledge and Kegan Paul.

Wright, J. and Kersner, M. (Eds.) (1990) *Working Together for Children with Communication Problems: Proceedings of a Study Day*. London: National Hospitals College of Speech Sciences.

Wright, J. A. (1995) *Collaboration between Speech and Language Therapists and Teachers*. Unpublished PhD, Institute of Education, University of London.

Appendices

Contents

Appendix 1

Additional information on distribution of postal questionnaires to and return rates from:

Speech & language therapy managers	Appendix 1.1
Speech & language therapists	Appendix 1.2

Appendix 2

Additional analyses of quantitative data collected through postal questionnaires from:

Speech & language therapy managers	Appendix 2.1
Speech & language therapists	Appendix 2.2
Teachers	Appendix 2.3
Parents	Appendix 2.4

Appendix 3

Speech & language therapy client groups, service groups and presenting disorders

Appendix 4

Speech & language therapy service standards for clients with developmental speech and language disorders

Appendix 5

Postal questionnaires appear with their original page numbering in the following order:

Speech & language therapy managers	Appendix 5.1
Speech & language therapists	Appendix 5.2
Advisers in special educational needs	Appendix 5.3
Educational psychologists	Appendix 5.4
Teachers	Appendix 5.5
Parents	Appendix 5.6

Additional information on the distribution of postal questionnaires to, and return rates from, speech & language therapy managers

Distribution of postal questionnaires is described and return rates given in Chapter 2. This Appendix provides additional information on the distribution and returns from speech & language therapy managers.

Questionnaires were sent to all speech and language therapy managers in Scotland and their deputies. Initially 68 forms were sent out but several managers found it easier to complete joint returns for geographic areas rather than complete a form for each administrative area, and often it was not appropriate for deputies to complete separate questionnaires. In addition, some managers who did not provide a service to clients under 18 years of age did not complete forms. The Table below shows how many questionnaires were sent to managers, how many were subsequently *not* expected to be returned and how many of those expected were returned. The return rate is based on the number of completed questionnaires and the number of expected returns.

Table 1.1a Questionnaire returns from speech & language therapy managers

Health Board Area/SCS & other*	No. sent to managers	No. not expected back because of joint returns	No. not expected back because of adult only service	No. of expected returns	No. of returns	% returned
Argyll & Clyde	3	0	0	3	3	100%
Ayrshire & Arran	1	0	0	1	1	100%
Borders	1	0	0	1	1	100%
Dumfries & Galloway	2	1	0	1	1	100%
Fife	3	2	0	1	1	100%
Forth Valley	3	0	0	3	3	100%
Grampian	9	4	0	5	5	100%
Greater Glasgow	13	1	2	10	10	100%
Highland	2	0	0	2	2	100%
Lanarkshire	3	0	0	3	3	100%
Lothian	10	1	0	9	8‡	89%
Tayside	7	4	0	3	3	100%
Orkney	1	0	0	1	1	100%
Shetland	1	0	0	1	1	100%
Western Isles	1	0	0	1	1	100%
SCS & other*	8	0	3	5	5	100%
TOTAL	*68*	*13*	*5*	*50*	*49*	*98%*

* Scottish Council for Spastics and one other independent school

‡ For one area in Lothian no managers' questionnaire was completed as the post of manager was vacant at the time of data collection

Additional information on the distribution of postal questionnaires to, and return rates from, speech & language therapists

Distribution of postal questionnaires is described and return rates given in Chapter 2. This Appendix provides additional information on the distribution and returns from SLTs.

Postal questionnaires were distributed to all speech & language therapists by their managers. All areas in Scotland were covered, including the one area in Lothian where the manager's post was vacant.

428 SLTs returned completed forms, which represents 65% of all SLTs in Scotland at 31 March 1994. Almost all of these SLTs (381; 89%) had a caseload which included children and young people. Of the SLTs who did not return completed forms, a significant number would not have had children and young people on their caseload according to the figures provided by speech & language therapy managers. From the Table below we can see that the data collected covers more than 75% of SLTs who had clients relevant to this project. The Table shows the number of SLTs working with children/young people, as noted by speech and language therapy managers, and how many competed forms were returned, by Health Board Area.

Table 1.2a **Questionnaire returns from speech & language therapists working with children and young people**

Health Board Area/SCS & other* /Independent¥	No. SLTs working with children/young people	No. of completed returns from SLTs who had under 18s on caseload	%
Argyll & Clyde	42	21	50%
Ayrshire & Arran	23	29	126%**
Borders	13	9	69%
Dumfries & Galloway	19	20	105%**
Fife	38	19	50%
Forth Valley	26	22	85%
Grampian	54	46	85%
Greater Glasgow	78	45	58%
Highland	27	21	78%
Lanarkshire	53	45	85%
Lothian	59†	51	<86%
Tayside	35	35	100%
Orkney	4	4	100%
Shetland	7	7	100%
Western Isles	5	4	80%
SCS & other*	14	6	43%
Independent¥	2	2	100%
TOTAL	*494*	*381*	~77%

* Scottish Council for Spastics and one other independent school
† This figure is lower than it should be as we had no data for one area in Lothian
¥ SLTs working independently but attached to universities/colleges
** Numbers are higher than expected because some managers did not count SLTs who unexpectedly had under 18s in their caseload at the time of data collection

BEST COPY AVAILABLE

Additional analyses of quantitative data from postal questionnaires to speech and language therapy managers

Speech & language therapists employed at 31 March 1994

Table 2.1a SLTs employed at 31 March 1994 and level of whole-time equivalent (WTE) posts: data from this project compared with Information & Statistics Division figures

	Number of SLTs, data from…		WTE posts, data from…	
Health Board Area	This project	ISD*	This project	ISD*
Argyll & Clyde	47	55	39.86	45.9
Ayrshire & Arran	32	37	34.4	34.5
Borders	18	25	13.2	15.1
Dumfries & Galloway	21	22	18.32	19.2
Fife	48	56	44.45	49.5
Forth Valley	26	27	20.1	22.4
Grampian	70	74	58.6	58.8
Greater Glasgow	107	128	83.7	106.9
Highland	29	25	25.17	20.7
Lanarkshire	66	64	53.8	54.0
Lothian	69	90	58.65	72.6
Tayside	47	47	40.2	38.5
Western Isles	5	6	4.6	4.9
Orkney	4	4	2.4	2.5
Shetland	2	2	2.0	2.0
TOTAL	*591*	*662*	*499.45*	*546.5*

* *ISD Health Briefing 95/07 notes that these figures are provisional*

The figures from this project are incomplete because several managers with an adult-only remit did not return forms. However, only in one area in Lothian, where the management post was vacant, and where there would have been SLTs treating under 18s, was no managers' questionnaire returned.

Figures do not include those reported by Scottish Council for Spastics (13 SLTs, 10.3 WTE posts) and one SLT employed by another independent school (1.0 WTE) posts.

Speech & language therapy assistants employed at 31 March 1994

Table 2.1b Speech and language therapy ASSISTANTS employed at 31 March 1994 and level of whole-time equivalent (WTE) posts: data from this project compared with Information & Statistics Division figures

	Number of speech and language therapy ASSISTANTS, data from...		WTE posts, data from...	
Health Board Area	This project	ISD*	This project	ISD*
Argyll & Clyde	2	2	1.7	0.9
Ayrshire & Arran	5	5	5.0	5.0
Borders	7	6	1.1	1.0
Dumfries & Galloway	1	1	0.5	0.5
Fife	5	5	3.0	4.5
Forth Valley	1	2	1.0	2.0
Grampian	3	3	1.5	1.5
Greater Glasgow	15	11	13.5	10.0
Highland	0	0	0	0
Lanarkshire	0	0	0	0
Lothian	0	0	0	0
Tayside	1	1	0.2	1.0
Western Isles	0	1	0	0.2
Orkney	0	0	0	0
Shetland	0	0	0	0
TOTAL	*40*	*37*	*27.5*	*26.6*

* ISD Health Briefing 95/07 notes that figures are provisional

The figures from this project are incomplete because several managers with an adult-only remit did not return forms. However, the above would suggest that we have most of the information regarding numbers of assistants in post, although there are a few discrepancies in the data compared with ISD figures.

Figures do not include Scottish Council for Spastics or the independent school included in the returns, but no therapy assistants were noted as employed by SCS or the independent school at 31 March 1994.

Speech & language therapists who worked with children and young people and the nature of their employment, full-time or part-time, 31 March 1994

The data collected from managers relates to 605 SLTs working in Scotland at 31 March 1994. Most SLTs who were working with under-18s are included as only one area, known to have clients under 18, was not covered by a returned questionnaire. The 605 includes 14 SLTs employed by agencies other than Health Boards and Trusts; excluding these 14, the number of SLTs noted here is 72 less than figures from official sources (ISD Scottish Health Service Common Service Agency, 1995).

Table 2.1c illustrates the numbers of SLTs working with children and young people and the nature of their employment. Table 2.1d shows the numbers of full- and part-time SLTs in each area, and Table 2.1e shows the numbers of full- and part-time assistants in each area.

It is clear from these figures that SLTs who work mainly with children and young people are in the majority (71%). 66% of the total are full-time SLTs who work mainly with under-18s, while a significant number (34%) of those working mainly with under-18s work part-time.

Table 2.1c Numbers* of SLTs working with children and young people, full- and part-time, as at 31 March 1994

	No.	%
Total number of SLTs	605	100%
Full-time	408	67%
Part-time	190	31%
Unknown work pattern	7	1%
Number of SLTs who are noted to work at all with children	497	82%
Total number of SLTs working MAINLY WITH CHILDREN	427	71%
Full-time SLTs	280	66%
Part-time SLTs	147	34%
Total number of SLTs working PARTLY WITH CHILDREN and PARTLY WITH ADULTS	46	8%
Full-time SLTs	37	80%
Part-time SLTs	9	20%
Total number of SLTs working MAINLY WITH ADULTS	115	19%
Full-time SLTs	89	77%
Part-time SLTs	26	23%
SLTs for whom working pattern & level of work with children is:		
Known	588	97%
Unknown	17	3%

* Numbers are mutually exclusive; no managers counted SLTs in more than one category

Table 2.1d Speech & language therapists working full-time and part-time by area

Health Board Area/SCS & other*	Number of SLTs Total	Full-time (% of area total)		Part-time (% of area total)		Unknown
Argyll & Clyde	47	31	(66%)	16	(34%)	
Ayrshire & Arran	32	27	(84%)	5	(16%)	
Borders	18	11	(61%)	7	(39%)	
Dumfries & Galloway	21	14	(67%)	7	(33%)	
Fife	48	39	(81%)	9	(19%)	
Forth Valley	26	16	(62%)	10	(38%)	
Grampian	70	44	(63%)	26	(37%)	
Greater Glasgow	107	68	(64%)	32	(30%)	7 (6%)
Highland	29	21	(72%)	8	(28%)	
Lanarkshire	66	44	(67%)	21	(32%)	1 (2%)
Lothian	69	42	(61%)	27	(39%)	
Tayside	47	29	(62%)	18	(38%)	
Western Isles	7	6	(86%)	1	(14%)	
Orkney	4	2	(50%)	2	(50%)	
Shetland	2	2	(100%)	0	(0%)	
SCS & other*	14	10	(71%)	4	(29%)	
TOTAL	*607*	*406*		*193*		*8*

Table 2.1e Speech & language therapy ASSISTANTS working full-time and part-time by area

Health Board Area/SCS & other*	Number of speech & language therapy assistants Total	Full-time	Part-time
Argyll & Clyde	2	0	2
Ayrshire & Arran	5	5	0
Borders	4	0	4
Dumfries & Galloway	1	0	1
Fife	9	1	8
Forth Valley	2	2	0
Grampian	3	0	3
Greater Glasgow	15	8	7
Highland	0	0	0
Lanarkshire	8	8	0
Lothian	0	0	0
Tayside	1	1	0
Western Isles	1	0	1
Orkney	0	0	0
Shetland	0	0	0
SCS & other*	0	0	0
TOTAL	57**	28	29

* Scottish Council for Spastics and one other independent school

** 28 of these 57 assistants work with children & young people. The additional 3 assistants counted in the ISD figures most likely work with adults.

Vacancies in the speech & language therapy service

Table 2.1f **Approved vacancies for SLTs across Scotland: numbers of full-time and part-time vacancies and WTE posts**

Health Board Area/SCS & other*	No. of full-time vacancies	No. of part-time vacancies	No. of WTE vacancies
Argyll & Clyde	[illegible]	[illegible]	[illegible]
Ayrshire & Arran	[illegible]	[illegible]	[illegible]
Borders	0	0	0
Dumfries & Galloway	[illegible]	[illegible]	[illegible]
Fife	[illegible]	[illegible]	[illegible]
Forth Valley	[illegible]	[illegible]	[illegible]
Grampian	[illegible]	[illegible]	[illegible]
Greater Glasgow	[illegible]	[illegible]	[illegible]
Highland	[illegible]	[illegible]	[illegible]
Lanarkshire	[illegible]	[illegible]	[illegible]
Lothian	[illegible]	[illegible]	[illegible]
Tayside	[illegible]	[illegible]	[illegible]
WESTERN ISLES	[illegible]	[illegible]	[illegible]
Orkney	0	0	0
Shetland	0	0	0
SCS & other*	0	0	0
TOTAL	[illegible]	[illegible]	[illegible]

Table 2.1g **Approved WTE vacancies for speech & language therapists across Scotland as a proportion of filled WTE posts**

Health Board Area/SCS & other*	No. of filled WTE posts	No. of WTE vacancies	% of WTE vacancies
Argyll & Clyde	[illegible]	[illegible]	[illegible]
Ayrshire & Arran	[illegible]	[illegible]	[illegible]
Borders	[illegible]	0	0%
Dumfries & Galloway	[illegible]	[illegible]	[illegible]
Fife	[illegible]	[illegible]	[illegible]
Forth Valley	[illegible]	[illegible]	[illegible]
Grampian	[illegible]	[illegible]	[illegible]
Greater Glasgow	[illegible]	[illegible]	[illegible]
Highland	[illegible]	[illegible]	[illegible]
Lanarkshire	[illegible]	[illegible]	[illegible]
Lothian	[illegible]	[illegible]	[illegible]
Tayside	[illegible]	[illegible]	[illegible]
Western Isles	[illegible]	[illegible]	[illegible]
Orkney	[illegible]	0	0%
Shetland	[illegible]	0	0%
SCS & other*	[illegible]	0	0%
TOTAL	[illegible]	[illegible]	

* [illegible]

Different types of locations receiving an on-site speech & language therapy service, and those 'requiring' such a service

Speech & language therapy managers supplied data on the numbers of different types of locations being provided with a speech & language therapy service, and those 'requiring' an on-site service, during the year 1 April 1993 to 31 March 1994. In order to compare the data with the figures collected for 1990 (Scottish Office Home and Health Department, 1993), managers were asked for data in the same categories of location and using very similar definitions for 'on-site provision' and 'requiring on-site provision.' These were as follows:

Locations with on-site provision were defined as:

> Locations where direct and/or indirect speech and language therapy was provided to children and young people during the year 1st April 1993 to 31st March 1994, including locations where blocks of treatment were provided during the year.

Locations where on-site therapy was required were defined as:

(i) Locations with 8 or more children/young people (0 – 18 years) who have been assessed as requiring regular speech and language therapy.

(ii) Locations with less than 8 children/young people (0 – 18 years) requiring regular speech and language therapy, and no other reasonable provision can be made (e.g. no clinic within reasonable travelling distance).

(iii) Locations with children/young people (0 – 18 years) with special needs (e.g. children with physical disabilities), where regular contact with a carer/teacher is required, and there is difficulty in getting to other locations for speech and language therapy.

(iv) Locations that are within an area of environmental deprivation where an on-site service may compensate for non-attendance, even although disorders may not be severe.

(v) Not locations that may be considered to require more therapy, only those where no therapy was provided but where therapy was required, as defined in i – iv above.

The following Tables show the numbers of different types of location with on-site therapy (Table 2.1b) and requiring on-site therapy (Table 2.1c) in 1990 and 1993/94.

Table 2.1b Locations WITH on-site speech & language therapy in 1990 and 1993/4

Type of location	Number of locations **with** on-site therapy provision		Increase/decrease between 1990 & 1993/94	
	NPAC data 31/3/90	This survey 31/3/94	No. of additional sites	% change
Mainstream facilities				
Mainstream primary schools	787	924	137	17%
Mainstream secondary schools	24	59	35	146%
Mainstream nurseries and nursery classes	137	298	161	118%
Special educational facilities for:				
Pupils with different levels of learning disabilities, i.e. some pupils with severe/profound, and others with mild/moderate learning disabilities	50	92	42	84%
Pupils with mild/moderate learning disabilities	58	96	38	66%
Pupils with severe/profound learning disabilities	67	53	-14	-21%
Pupils with hearing impairments	18	23	5	28%
Pupils with visual impairments	5	6	1	20%
Pupils with physical disabilities	8	16	8	100%
Pupils with specific language disorders	22	35	13	59%
Pupils with pervasive communication disorders (includes schools for children and young people on the autistic continuum)	14	12	-2	-14%
Pupils with emotional/behaviour difficulties	2	5	3	150%
Psychological service department locations not included in any of the above	14	9	-5	-36%
Locations in health service premises				
Health centres/clinics	256	265	9	4%
Paediatric assessment units (community based)	10	15	5	50%
Hospitals	78	78	0	0%
Hospital assessment units	4	9	5	125%
Hospital schools	5	7	2	40%
Day hospitals/centres	4	28	24	600%
Locations provided by social work depts.				
Pre-school children's centres and other locations catering for pre-school children	45	46	1	2%
Other provision				
Provision predominantly at home	515	854	339	66%
Mobile therapy units		3*		
Establishments run by voluntary organisations	5	14	9	180%
Other types of establishment catering for children and young people (0 – 18 years)	10	24	14	140%

* These may be new or have been counted in 'other' by NPAC study

Numbers of different types of location/sites recorded as **requiring** speech and language therapy input and comparisons with 1990 figures collected by NPAC (SOHHD, 1993). Negative changes indicate a fall in the number of sites requiring but not getting on-site provision between 1990 and 1994. In many cases managers emphasised that their figures were estimates. This is especially true of 'provision predominately at home'.

Table 2.1i Locations WITHOUT but requiring on-site speech & language therapy in 1990 and 1993/94

Type of location	Number of locations **without** on-site therapy provision		Increase/decrease between 1990 & 1993/94	
	NPAC data 31/3/90	This survey 31/3/94	No. of additional sites	% change
Mainstream educational facilities				
Mainstream primary schools	177	80	-97	-55%
Mainstream secondary schools	19	36	17	90%
Mainstream nurseries and nursery classes	111	65	-46	-41%
Special educational facilities for:				
Pupils with different levels of learning disabilities, i.e. some pupils with severe/profound, and others with mild/moderate learning disabilities	3	4	1	33%
Pupils with mild/moderate learning disabilities	13	2	-11	-85%
Pupils with severe/profound learning disabilities	10	2	-8	-80%
Pupils with hearing impairments	13	8	-5	-39%
Pupils with visual impairments	1	1	0	0%
Pupils with physical disabilities	2	0	-2	-100%
Pupils with specific language disorders	1	5	4	400%
Pupils with pervasive communication disorders (includes schools for children and young people on the autistic continuum)	0	1	1	-
Pupils with emotional/behaviour difficulties	7	13	6	86%
Psychological service department locations not included in any of the above	4	3	-1	-25%
Locations in health service premises				
Health centres/clinics	30	39	9	30%
Paediatric assessment units (community based)	0	1	1	-
Hospitals	5	7	2	40%
Hospital assessment units	0	2	2	-
Hospital schools	0	0	0	0
Day hospitals/centres	0	1	1	-
Locations provided by social work depts.				
Pre-school children's centres and other locations catering for pre-school children	34	33	1	3%
Other provision				
Provision predominantly at home	41	46	-5	-12%
Mobile therapy units	n/a			
Establishments run by voluntary organisations	1	2	1	50%
Other types of establishment catering for children and young people (0 – 18 years)	2	3	1	33%

Additional analyses of quantitative data from postal questionnaires to speech & language therapists

381 speech & language therapists with children and young people in their caseloads returned completed questionnaires. The following analyses are based on data from these SLTs. Most analyses are considered with respect to 'old' Health Board areas.

Generalists, specialists and SLTs who have a special interest or expertise

162 (43%) SLTs identified themselves as 'specialists' and a further 89 (23%) as 'generalists, but with a special interest/expertise'. 33% (126) of respondents identified themselves as 'generalists'. 4 SLTs did not respond to the question.

Table 2.2a Numbers of speech & language therapists: generalists: specialists and SLTs with a special interest or expertise

Health Board Area/ SCS & other*/ Independent¥	'Specialists' (% of area total)		'Generalists with special interest/expertise' (% of area total)		'Generalists' (% of area total)		Total
Argyll & Clyde	9	(43%)	5	(24%)	7	(33%)	21
Ayrshire & Arran	12	(41%)	10	(34%)	7	(24%)	29
Borders	4	(44%)	1	(11%)	4	(44%)	9
Dumfries & Galloway	6	(30%)	5	(25%)	9	(45%)	20
Fife	11	(58%)	3	(16%)	5	(26%)	19
Forth Valley	10	(48%)	4	(19%)	7	(33%)	21
Grampian	20	(43%)	8	(17%)	18	(39%)	46
Greater Glasgow	29	(63%)	7	(15%)	10	(22%)	46
Highland	6	(30%)	5	(20%)	9	(45%)	20
Lanarkshire	13	(30%)	11	(25%)	20	(45%)	44
Lothian	25	(51%)	11	(22%)	14	(29%)	49
Tayside	10	(29%)	13	(37%)	12	(34%)	35
Orkney	0	(0%)	2	(50%)	2	(50%)	4
Shetland	0	(0%)	1	(50%)	1	(50%)	2
Western Isles	2	(50%)	1	(25%)	1	(25%)	4
SCS & other*	5		0		0		5
Independent¥	0		2		0		2
Total	*162*	*(43%)*	*89*	*(24%)*	*126*	*(33%)*	*377*

* Scottish Council for Spastics and one other independent school
¥ SLTs working independently but attached to universities/colleges

Most of the 251 SLTs who identified themselves as 'specialists' or 'generalists, but with a special interest/expertise' noted their various specialisms, special interests or expertise. These have been categorised and are shown in the Table below. The largest grouping lies in the general area of children with special educational needs.

Table 2.2b Speech & language therapists with specialisms, special interests or expertise

Specialism, special interest or expertise	Number of SLTs
Special educational needs/liaison with Education/children with Records of Needs	53
Children with learning difficulties	42
Specific language impairment/child language disorders	37
Children with hearing impairment	14
Children with physical disability	13
Pre-school children	11
Children with multiple handicap	10
Alternative & augmentative communication (AAC)	10
Autism/pervasive communication disorder	5
Dysfluency/stammering	5
Cleft lip and palate	3
Phonology	2
Bilingualism	2
Children with emotional & behavioural difficulties	2
Paediatric assessment	2
Paediatric eating and drinking	1
(Specialism related to work with adults)	(25)
(Specialism not specified)	(14)
Total	*251*

Caseloads of 381 speech & language therapists working with children and young people

Prioritisation

- 82% (312) of SLTs prioritised their caseload in some way
- 17% (63) SLTs said they did not prioritise their caseload
- 1% (5) did not respond to this question

Individual or shared caseloads

SLTs were asked whether they had individual caseloads or whether they had a shared or team caseload. 77% of these SLTs had individual responsibility for their caseload but 22% had all or part of their caseload shared with another therapist or team.

Table 2.2c SLTs with individual and shared/team caseloads

Type of caseload	Number of SLTs	%
Individual responsibility	295	77%
Shared/team responsibility	31	8%
Mixed caseload: part individual part shared/team	52	14%
Unknown	3	1%
Total	*381*	

Numbers of under-18 year olds on SLTs' caseloads

14 SLTs did not report caseload numbers. For the 367 SLTs who did provide caseload figures:

- the range was 1 to 430
- the mean caseload was 60 with a standard deviation of 50
- the median caseload was 50 with a midspread (interquartile range) from 26 to 82

(NB These figures do not take into account any adults on SLTs' caseloads.)

Table 2.2d Numbers of under-18s on speech & language therapists' caseloads

Number of under-18s on caseload	Number of SLTs	%
10 or fewer children	36	9%
11 - 20	37	10%
21 - 30	41	11%
31 - 40	36	9%
41 - 50	35	9%
51 - 60	33	9%
61 - 70	28	7%
71 - 80	28	7%
81 - 90	23	6%
91 - 100	17	4%
101 - 150	38	10%
151 - 250	11	3%
251 - 430	4	1%
numbers in caseload not given	14	4%
Total	*381*	

Gender and age of children/young people on SLTs' caseloads

All but 14 of the 381 SLTs with children and young people on their caseloads gave the numbers of children/young people 'on their books' by gender and age group. The 367 SLTs who detailed their caseloads recorded 21,934 children and young people. The following Tables show these data.

Table 2.2e Children and young people on the caseloads of 381 speech & language therapists in Scotland by age and gender

	0-4 years	5-11 years	12-18 years	Total
Boys	**5,707**	**7,851**	**1,154**	**14,712**
	(26%)	(36%)	(5%)	(67%)
Girls	**2,811**	**3,663**	**748**	**7,222**
	(13%)	(17%)	(3%)	(33%)
Total	***8,518***	***11,514***	***1,902***	***21,934***
	(39%)	*(52%)*	*(9%)*	

Table 2.2f Children and young people on the caseloads of 381 speech & language therapists in Scotland by age and area

Health Board Area /SCS & other* (return rate from SLTs†)		0-4 years	5-11 years	12-18 years	Total
Argyll & Clyde	(50%)	310	486	113	909
Ayrshire & Arran	(100%)	872	1252	150	2,274
Borders	(69%)	162	326	17	505
Dumfries & Galloway	(100%)	527	415	43	985
Fife	(50%)	277	358	100	735
Forth Valley	(85%)	562	846	105	1,513
Grampian	(85%)	981	1,294	144	2,417
Greater Glasgow	(58%)	1,213	1,210	485	2,908
Highland	(79%)	413	841	98	1,352
Lanarkshire	(85%)	974	1,199	226	2,399
Lothian	(86%)	1,159	1,433	236	2,828
Tayside	(100%)	905	1,061	136	2,102
Orkney	(100%)	57	581	8	646
Shetland	(100%)	44	76	6	126
Western Isles	(80%)	29	101	17	147
SCS & other*	(43%)	30	26	22	78
Independent¶	(100%)	3	9	1	13
Total	*(77%)*	*8,518*	*11,514*	*1,902*	*21,934*

* *Scottish Council for Spastics and one other independent school*

† *Proportion of SLTs known to work with children/young people who returned questionnaires*

¶ *SLTs working independently but attached to universities/colleges*

157

Additional analyses of quantitative data from postal questionnaires to teachers

The following analyses are based on the data collected from the 814 teachers who returned completed postal questionnaires. Primarily, only the responses of the 526 teachers who taught/worked with pupils receiving speech & language therapy at the time they completed the questionnaire are considered (239 mainstream teachers and 287 special education teachers). Occasionally data from all 814 teachers are included in the analyses (460 mainstream teachers and 354 special education teachers). Most of the data are considered with respect to whether the teachers work in mainstream schools or special educational settings, some of which may be part of a mainstream school. Not all teachers answered every question, therefore in some instances responses are incomplete.

Table 2.3a **Do teachers feel they have more pupils in their classes, or with whom they work, who would benefit from speech & language therapy? (Data from all 814 teachers*; Q5 in postal questionnaire)**

	Mainstream teachers		Special education teachers	
How teachers felt	No.†	%‡	No.†	%‡
YES they had other pupils who would benefit from speech & language therapy	**244**	53%	**118**	33%
NO they did not have other pupils who would benefit from speech & language therapy	**79**	17%	**150**	42%
UNSURE about whether they had pupils who would benefit from speech & language therapy	**38**	8%	**25**	7%
No response	**99**	22%	**61**	17%
Totals	***460***		***354***	

* 460 mainstream teachers and 354 special education teachers
† numbers NOT mutually exclusive
‡ % of 460 mainstream teachers and % of 354 special education teachers

Table 2.3b What personal, one-to-one contact do teachers have with SLTs? (Data from 526 teachers* with pupils receiving therapy; Q7 in postal questionnaire)

	Mainstream teachers		Special education teachers	
Type of contact teachers with SLTs	No.†	%‡	No.†	%‡
No one-to-one contact now or in the past	39	16%	9	3%
No current one-to-one contact, but some in past	27	11%	8	3%
Regular, timetabled, one-to-one contact	20	8%	72	25%
Regular but informal contact (e.g. during breaks)	85	36%	176	61%
Occasional one-to-one contact at request of teacher	71	30%	81	28%
Occasional one-to-one contact at request of SLT	46	19%	78	27%

* 239 mainstream teachers and 287 special education teachers
† numbers NOT mutually exclusive
‡ %s of 239 mainstream teachers and %s of 287 special education teachers

Table 2.3c Characteristics of the personal contact teachers have with SLTs (Data from 526 teachers* with pupils receiving therapy; Q9 in postal questionnaire)

Characteristics of contact teachers have with SLTs	Mainstream teachers		Special education teachers	
	No.†	%‡	No.†	%‡
Reporting and feedback				
Teacher reports and gives feedback (verbal or written) to SLT on educational programme or assessment	79	33%	182	63%
SLT gives and gives feedback (verbal or written) to teacher on therapy assessment results and progress	124	52%	230	80%
Observation				
SLT has observed classroom work	41	17%	166	58%
Teacher has observed SLT working with pupils	32	13%	142	49%
Joint work and joint planning				
Teacher and SLT work together in the classroom with individuals or groups of pupils	13	5%	110	38%
Teacher and SLT plan together educational programmes (or part of programmes)	19	8%	100	35%
Teacher and SLT plan together speech & language therapy programmes (or part of programmes)	31	13%	125	44%
Guidance and advice				
Teacher offers guidance/advice to SLT	34	14%	149	52%
SLT offers guidance/advice to teacher	107	45%	216	75%

* 239 mainstream teachers and 287 special education teachers. [illegible] teachers have no current contact with SLTs ([illegible] mainstream teachers and [illegible] special education teachers)
† contacts NOT mutually exclusive
‡ %s of 239 mainstream teachers and %s of 287 special education teachers

Table 2.3d What changes in the contact they have with SLTs would teachers prefer?
(Data from 526 teachers* with pupils receiving therapy; Q10 in postal questionnaire)

	Mainstream teachers		Special education teachers	
Preferred changes in contact teachers with SLTs	No.†	%‡	No.†	%‡
No change, contact satisfactory	**45**	(19%)	**92**	(32%)
More time/greater number of meetings, type of contact satisfactory	**44**	(18%)	**88**	(31%)
Less time/fewer meetings, type of contact satisfactory	**0**	(0%)	**0**	(0%)
More formal arrangements for liaison	**83**	(35%)	**50**	(17%)
More formally allocated time for liaison	**101**	(42%)	**98**	(34%)

* 239 mainstream teachers and 287 special education teachers
† numbers NOT mutually exclusive
‡ % of 239 mainstream teachers and % of 287 special education teachers

Table 2.3e How many teachers attend multi-professional meetings concerning pupils with speech, language and communication problems?
(Data from 526 teachers* with pupils receiving therapy; Q11 in postal questionnaire)

	Mainstream teachers		Special education teachers	
Type of meeting	No.†	%‡	No.†	%‡
Teachers attending future needs meetings	**39**	(16%)	**124**	(43%)
Teachers attending case conferences	**50**	(21%)	**122**	(43%)
Teachers attending review meetings	**77**	(32%)	**236**	(82%)
Teacher attending other multi-professional meetings	**8**	(3%)	**13**	(5%)
Teachers who stated they did not attend any multi-professional meetings	**117**	(49%)	**28**	(10%)

* 239 mainstream teachers and 287 special education teachers
† numbers NOT mutually exclusive
‡ % of 239 mainstream teachers and % of 287 special education teachers

BEST COPY AVAILABLE

Table 2.38 **What factors do teachers report as having an effect on their contact with SLTs? (Data from 528 teachers[1] with pupils receiving therapy; Q12 in postal questionnaire)**

	Mainstream teachers		Special education teachers	
Factors which affect contact with SLTs	No.[2]	%[3]	No.[2]	%[3]
Teachers do not have time to speak with SLTs	84	[illegible]	108	[illegible]
Teachers are not invited by SLTs to have contact	81	[illegible]	28	[illegible]
SLTs do not have time to speak with teachers	88	[illegible]	87	[illegible]
Teachers are not invited to consultancy meetings	61	[illegible]	27	[illegible]
Teachers are invited but do not have time to attend consultancy meetings	7	[illegible]	5	[illegible]
Teachers do not have (or have been refused) permission to spend time out of the classroom for such contact or meetings	18	[illegible]	14	[illegible]
Teachers do not feel it is an appropriate way to spend their time	5	[illegible]	8	[illegible]
Teachers feel it is not necessary to spend time with SLT as other members of staff liaise with SLT	14	[illegible]	8	[illegible]
Other factors which inhibit contact (several teachers mentioned the difficulties as a combination of teachers and SLTs)	17	[illegible]	33	[illegible]

[1] 239 mainstream teachers and 287 special education teachers

[2] questions NOT mutually exclusive

[3] % of 239 mainstream teachers and % of 287 special education teachers

Table 3.3g Teachers who had classroom assistance, such as nursery nurses, team teachers, ancillaries and voluntary aides (including parent helpers) involved with speech & language therapy programmes
(Data from 526 teachers¹ with pupils receiving therapy; Q17 in postal questionnaire)

Teachers with:	Mainstream teachers No.	(%)²	Special education teachers No.	(%)²
No classroom assistants	58	[illegible]	46	[illegible]
One or more classroom assistants but no speech & language therapy programmes	43	[illegible]	28	[illegible]
One or more classroom assistants but they are not involved with existing speech & language therapy programmes	33	[illegible]	47	[illegible]
One or more classroom assistants who are involved with one or more of the existing speech & language therapy programmes	79	[illegible]	132	[illegible]
One or more classroom assistants who have previously been involved with speech & language therapy programmes	8	[illegible]	8	[illegible]
No response	18	[illegible]	17	[illegible]
Total	239		287	

1 239 mainstream teachers and 287 special education teachers
2 % of 239 mainstream teachers and % of 287 special education teachers

Table 3.3h Do teachers have contact with parents of pupils with regard to their child's speech & language therapy programme?
(Data from 526 teachers¹ with pupils receiving therapy; Q16 in postal questionnaire)

Contact with parents	Mainstream teachers No.	(%)²	Special education teachers No.	(%)²
Yes, teachers have contact	159	[illegible]	196	[illegible]
No, teachers do not have contact	76	[illegible]	78	[illegible]
No response	4	[illegible]	13	[illegible]
Total	239		287	

1 239 mainstream teachers and 287 special education teachers
2 % of 239 mainstream teachers and % of 287 special education teachers

Table 2.6 What in-service training /staff development have teachers been involved in which included SLT? (Data from all [illegible] teachers*; Q8 in postal questionnaire)

Type of development	Mainstream teachers No.	Mainstream teachers (%)	Special education teachers No.	Special education teachers (%)
NOT involved in any in-service training that included SLT	[illegible]	[illegible]	[illegible]	[illegible]
Involved in in-service training [illegible] SLT	8	[illegible]	[illegible]	[illegible]
Involved in in-service training [illegible] SLT	[illegible]	[illegible]	[illegible]	[illegible]
Involved in in-service training [illegible] SLT	[illegible]	[illegible]	[illegible]	[illegible]

---

* [illegible]

† [illegible]

[illegible]

[illegible]		[illegible]		[illegible]	
		No.	%	No.	%
(a)	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
(b)	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
(c)	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
(d)	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
(e)	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
(f)	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
(g)	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
(h)	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
(i)	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
(j)	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
(k)	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
(l)	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
(m)	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
(n)	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

[illegible]

[illegible]

[illegible]

Table 2.36 Beneficial changes selected by teachers as those which should receive THE HIGHEST PRIORITY
(Data from 526 teachers* with pupils receiving therapy; Q15 in postal questionnaire)

High priority options?	Mainstream teachers No.†	Mainstream teachers %‡	Special education teachers No.†	Special education teachers %‡
(a) *Official encouragement* to teachers to *give priority* to liaison and work with speech and language therapist/s	42	18%	31	11%
(b) More speech and language therapy *outside the classroom*	45	19%	31	11%
(c) More support from speech and language therapist/s *for pupils in the classroom*	63	26%	66	23%
(d) More *joint planning* by teachers and speech and language therapists	76	32%	96	33%
(e) More *collaborative work in the classroom* between teachers and speech and language therapists	67	28%	93	32%
(f) More *training* for speech and language therapists about *education* in schools and the curriculum	13	5%	34	12%
(g) More *training* for teachers about speech, language and communication	82	34%	123	43%
(h) More *joint training* for teachers and speech and language therapists	49	21%	80	27%
(i) More involvement of teachers in the *development of curriculum based speech and language therapy programmes*	20	8%	54	19%
(j) More involvement of speech and language therapists in *curriculum development programmes*	21	9%	38	13%
(k) More information for teachers about the speech and language therapy *service* and how the service relates to specific schools	38	16%	30	10%
(l) More classroom assistants dedicated to supporting pupils with speech and language problems	46	19%	38	13%
(m) More *classroom assistants generally*	59	25%	39	13%
(n) Teachers being able to attend sometimes *meetings about individual pupils* with speech, language and communication problems, meetings such as case conferences and future needs meetings	25	10%	13	4%

* 239 mainstream teachers and 287 special education teachers
† numbers NOT mutually exclusive
‡ % of 239 mainstream teachers and % of 287 special education teachers

Additional analyses of quantitative data from postal questionnaires to parents

The following Tables provide additional analyses of data collected from parents through postal questionnaires. 520 parents returned completed questionnaires. The data are considered as a whole and in terms of the following divisions:

- whether parents requested questionnaires or whether they received them from their child's SLT
- whether the children are of pre-school, primary or secondary age
- whether the children are pupils in mainstream or special educational settings

Table 2.4a Postal questionnaires returned from parents in different areas, by request or distribution through speech & language therapists (Data from all 520 parents*)

	Returns from parents who requested forms		Returns from parents who received forms from SLTs		Total returns	
Region	No.	%ᵃ	No.	%ᵃ	No.	%ᵇ
Argyll & Clyde	**10**	5%	**25**	8%	**35**	7%
Ayrshire & Arran	**5**	3%	**15**	5%	**20**	4%
Borders	**5**	3%	**12**	4%	**17**	3%
Dumfries & Galloway	**5**	3%	**19**	6%	**24**	5%
Fife	**19**	10%	**15**	5%	**34**	7%
Forth Valley	**14**	7%	**17**	5%	**31**	6%
Grampian	**23**	12%	**48**	15%	**71**	14%
Greater Glasgow	**45**	24%	**40**	12%	**85**	16%
Highland	**11**	6%	**15**	5%	**26**	5%
Lanarkshire	**6**	3%	**37**	11%	**43**	8%
Lothian	**40**	21%	**45**	14%	**85**	16%
Tayside	**4**	2%	**25**	8%	**29**	6%
Orkney	**4**	2%	**5**	1%	**9**	2%
Shetland	**0**	0%	**4**	1%	**4**	<1%
Western Isles	**0**	0%	**7**	2%	**7**	1%
Totals	***191***		***329***		***520***	

* 191 returned questionnaires had been requested by parents; 329 had been distributed by SLTs

a %s of 191 parents who requested questionnaires and %s of 329 parents who received questionnaires from their child's SLT

b %s of all 520 parents

The sample of children referred to by returns from parental survey appears similar to that of the total caseloads in the SLTs' survey (see *Table 2.2e above*) in terms of gender ratio (2.5 boys to 1 girl in parents' and 2.0 boys to 1 girl in the SLTs' survey). Pre-school children are somewhat under-represented in the parents' survey compared to the SLTs', and both primary and secondary children/young people are slightly over-represented.

Table 2.4b Boys and girls in different age groups (Data from all 520 parents*)

	Pre-school (0 - 4 years)		Primary (5 - 11 years)		Secondary (12 - 19 years)		Total	
	Nos	%	Nos	%	Nos	%	Nos	%
Boys	**100**	19%	**220**	42%	**50**	10%	**370**	71%
Girls§	**40**	8%	**90**	17%	**15**	3%	**148**	29%
Totals	***140***	*27%*	***310***	*60%*	***65***	*13%*	***518***	

* Each questionnaire related to only 1 child

§ the ages of 3 girls were unknown

Early referral to speech & language therapy services is reflected in returns from the survey of parents, as seen in the Table below.

Table 2.4c Age at which children *first* saw a speech & language therapist (Data from all 538 parents*)

	Pre-school (0 - 4 years)		Primary (5 - 11 years)		Secondary (12 - 19 years)	
	%s	(N)	%s	(N)	%s	(N)
Children who *first* saw a SLT when they were ...	**86.6**	[illegible]	**8.5**	[illegible]	**5**	[illegible]

* Each questionnaire related to only 1 child

§ % of all 538 children; 7 children had not seen a SLT and a further 8 parents did not know the age their child first saw a SLT

Table 2.44 Whether or not parents had *ever* been given a diagnosis or 'label' for their child's difficulties, by current age group of child (Data from all 520 parents¹)

Whether parents have been given a diagnosis for their child's difficulties	Pre-school (0 - 5 years)		Primary (5 - 11 years)		Secondary (12 - 18 years)	
	No.	%²	No.	%²	No.	%²
YES children of parents who have been given a diagnosis	**72**	[illegible]	**204**	[illegible]	**50**	[illegible]
NO children of parents who have not been given a diagnosis	**63**	[illegible]	**101**	[illegible]	**18**	[illegible]
No response	**5**	[illegible]	**5**	[illegible]	**1**	[illegible]
Totals	***140***		***310***		***69***	

1. Each questionnaire related to only 1 child
2. % of 140 pre-school children; 310 primary aged pupils and 69 secondary aged pupils; [illegible]

Table 2.6 Whether or not children had a Records of Needs (Data from all 520 parents*)

Whether children have a Record of Needs	Returns from parents who requested forms		Returns from parents who received forms [illegible]	
	No.	%	No.	%
YES, child had a Record of Needs	**129**	[illegible]	**159**	[illegible]
NO, child did not have a Record of Needs	**37**	[illegible]	**109**	[illegible]
A Record of Needs was **being opened** at the time of completing the questionnaire	**18**	[illegible]	**34**	[illegible]
No response	**7**	[illegible]	**27**	[illegible]
Totals	**191**		**329**	

[illegible] 191 returned questionnaires had been requested by parents, 329 had been distributed by [illegible]

[illegible]

Table 2.4f **Whether or not children use signing, symbols or a communication aid (Data from all 528 parents)**

	No.	%*
YES, child uses signing, symbols or a communication aid	133	25%
NO, child does not use signing, symbols or a communication aid	374	71%
No response	21	4%
Totals	528	

* % of all 528 parents

Table 2.4g **Whether or not the 133 children who use signing, symbols or a communication aid have staff available in school or nursery who are familiar with their method of communication (Data from 133 parents, see Table 2.4f above)**

	No.	%*
Usually, someone is available to help the child use signing, symbols or a communication aid	103	77%
Sometimes, someone is available to help the child use signing, symbols or a communication aid	8	6%
No one is available to help the child use signing, symbols or a communication aid	6	5%
Not sure	5	4%
No response	11	8%
Totals	133	

Table 2.4h **Whether parents of the 133 children who use signing, symbols or a communication aid felt the SLT was skilled in the use of their children's method of communication (Data from 133 parents, see Table 2.4f above)**

	No.	%*
Yes, SLT is skilled in the use of signing, symbols or a communication aid	113	85%
No, SLT is not skilled	6	5%
Not sure whether SLT is skilled	9	7%
No response	5	4%
Totals	133	

Table 2.6 Whether or not the 155 children who use signing, symbols or a communication aids are encouraged to use these forms of communication at school
(Reply from 155 parents; see Table 2.8 above)

	No.	%
Child is ENCOURAGED to use signing, symbols or a communication aid	[illegible]	[illegible]
Child is DISCOURAGED to use signing, symbols or a communication aid	[illegible]	[illegible]
Child is NEITHER encouraged nor discouraged to use signing, symbols or a communication aid	[illegible]	[illegible]
Not sure	[illegible]	[illegible]
No response	[illegible]	[illegible]
Total	155	

Table 2.4(i) Whether or not parents thought their children had enough opportunities to work alongside other children during the school day (Data from [illegible] parents who had children attending particular educational settings)

Whether child had/has enough opportunities to work with other children	parents with children in mainstream schools		parents with children in special educational settings	
	No.	(%)	No.	(%)
YES, child had enough opportunities to mix with other children	[illegible]	[illegible]	[illegible]	[illegible]
NO, child did not have enough opportunities to mix	[illegible]	[illegible]	[illegible]	[illegible]
Not sure	[illegible]	[illegible]	[illegible]	[illegible]
No response	[illegible]	[illegible]	[illegible]	[illegible]
Total	[illegible]		[illegible]	

* % of [illegible] parents with children in mainstream schools and % of [illegible] parents with children in special educational settings

Table [illegible] [illegible]

[illegible]	No.	[illegible]	No.	[illegible]
Daily	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Weekly	[illegible]	[illegible]	[illegible]	[illegible]
Monthly	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Total	[illegible]		[illegible]	

[illegible]

[illegible]

	[illegible]		[illegible]		[illegible]	
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

[illegible]

[illegible]

	[illegible]		[illegible]		[illegible]	
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

[illegible]

Speech & Language Therapy Client Groups, Service Groups and Presenting Disorders

College of Speech & Language Therapists (1991) Communicating Quality: Professional Standards for Speech and Language Therapists. London: CSLT.

Client Groups

- Learning difficulties (Mental Handicap)
- Hearing Impairment
- Physical disability
- The Autistic Continuum
- Cleft Lip/Palate and Velopharyngeal Anomalies
- Acquired Neurological Disorders:
  - Progressive Neurological Disorders
  - Cerebral Vascular Accident
  - Traumatic Brain Injury
  - Neurosurgery
  - Dementia
- Speech & language therapy in a multi-racial, multi-cultural society

Service Groups

- Mental Health
  - Adults
  - Children
- ENT Services
  - Voice
  - Laryngectomy
- Head & neck surgery (including maxillofacial surgical procedures)
- The Elderly Population
- Alternative and Augmentative Communication
- Counselling

Presenting Disorders

- Acquired Language Disorder (incl. Aphasia)
- Acquired Childhood Aphasia
- Developmental Speech and Language Disorders
- Written language disorders:
  - Developmental
  - Acquired
- Developmental Dyspraxia
- Acquired Dyspraxia
- Acquired Fluency Disorders
- Dysphonia
- Dysfluency
- Dysphagia
- Eating and drinking difficulties in children

Speech & language therapy service standards for clients with developmental speech & language disorders

[illegible]

Developmental Speech and Language Disorders

Definition/Description of Client Group

[illegible]

Aims/Principles of Service Delivery

1. [illegible]
    - [illegible]
    - [illegible]
    - [illegible]
    - [illegible]
    - [illegible]
2. [illegible]
3. [illegible]
4. [illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

- [illegible]
- [illegible]
- [illegible]
- [illegible]
- [illegible]
- [illegible]
- [illegible]
  - [illegible]
  - [illegible]
  - [illegible]
- [illegible]
- [illegible]
- [illegible]

[illegible]

- phonology
  - assessment of phonological system
  - analysis of phonological processes
  - assessment of intelligibility
  - assessment of self monitoring skills
- articulation
  - assessment of phonetic system
  - analysis of phonetic errors
  - assessment of intelligibility
  - assessment of self monitoring skills
- voice
- prosody
- auditory skills
- visual skills
- tactile skills
- kinaesthetic skills
- cross modal skills
- gross and fine motor skills

7 Assessment should include the assessment of non-verbal skills as appropriate to the individual child. It may be indicated that information provided by other professionals may more appropriately form this part of the assessment.

8 Information on any of the above areas should include observations from the parents/carers/child and other professional as well as the speech and language therapist's own findings.

9 Assessments should reflect the child's functioning in his/her own communication environment and therefore may include observations in the home, nursery, school and clinic.

10 Assessment should reflect the child's communication in a variety of situations and therefore should include observations of the child's communication with parents/carers, siblings, peers and both familiar and unfamiliar adults. Assessment should also include observations of the child on both group and individual basis.

11 Assessment will include the findings of other professionals involved with the child in relation to other areas of functioning as well as speech and language skills.

12 Assessment should include joint assessment with other professionals which may be through a joint visit or by meetings/liaison.

13 Assessment will include looking at the need, appropriateness and timing of intervention which will be established in consultation with the parents/carers, child and other professionals. It should include assessment of the child's need, readiness and ability to change.

14 Assessment may involve specialist advice, which may be through the use of specialist speech and language therapists in or out of the Employing Authority, involvement of other professionals and referral to centres of specialism in specific clinical fields. This should be in consultation with parents/carers and other professionals.

15 Assessment must include the discussion and reporting of findings with parents/carers and other professionals as well as the child where appropriate. This should include the formation of a management plan detailing the aims and objectives of a period of intervention which should be planned with parents/carers, child and other professionals.

Intervention:

1 **Intervention should be planned in conjunction with the child/parent/carer and other professionals as appropriate and should be based upon assessment findings.**

2 *Intervention may be carried out by the therapist directly or indirectly; it may also be facilitated by the therapist and carried out by e.g. the parents. Intervention is the joint responsibility of therapist, child, parent/carer and/or other professionals.*

3 **Intervention will include the setting of specific goals, which should be recorded as expected outcomes and evaluated as actual outcomes with a specified timescale.** *Intervention should be modified accordingly.*

4 *During the process of intervention there must be constant reassessment of the child's performance and need for intervention.*

5 *Intervention may take the form of individual, paired or group work as appropriate.*

6 *An episode of intervention must be agreed with the parents/carers and other professionals as appropriate. For those professionals involved with the child but not directly involved in the child's speech and language programme, the therapist should attempt to ensure that they are kept fully informed.*

7 *The agreement between the therapist and parents/carers/other professionals should outline the location of the contact, the frequency of contact, the nature of the contact and their respective responsibilities.*

8 *Intervention must always include consideration of the child's need to change.*

9 *Intervention must always include consideration of the child's readiness to change.*

10 *Intervention must always include consideration of the child's ability to change.*

As part of intervention, consideration must be given to the relevance of activities and the appropriateness of materials.

11 *As part of intervention, consideration must be given to the child's non-linguistic needs/concerns.*

12 *Intervention should aim to work from a basis of success.*

13 *Intervention should aim to use the child's strengths to counteract weaknesses.*

14 *Intervention should focus on those areas of speech and language performance in which the child is most likely to effect change and where such change would provide the maximum results in terms of overall communication competence.*

15 *Intervention should address the child's total communication needs and may involve the use of support systems, e.g. sign, colour coding.*

16 *Intervention must work towards offering the child strategies, so that he/she is empowered to manage his/her communication difficulties effectively. This may involve educating parents/carers/other professionals of such strategies locally, within the child's functional communication setting.*

17 *Intervention may involve the child in discussion of his/her difficulties and the effect of communication impairment. For example, as a child's sound system changes, he/she may continue to believe that his/her system demonstrates errors that no longer exist, and whilst this may be due partly to poor self-monitoring, it may also be due to negative self image.*

18 *It should also be noted that intervention represents change and the risk of change should be acknowledged. For example, the child who presents with a speech and language difficulty relating to production may feel safe with his productions/realisations, despite frustration, embarrassment etc., because he/she is confident about the level of intelligibility. During intervention he/she may feel*

anxious that intelligibility could lessen, but equally he/she may feel anxious that if intelligibility increases, other expectations/demands will be made upon him/her.

19 Intervention within a school setting may include the provision of a written programme outlining areas of strengths/weaknesses as well as specific strategies/ideas for intervention. This should be jointly planned with education staff to fit in with the child's overall educational programme and address education issues, including access to the National Curriculum where appropriate.

20 Intervention should include the provision of in-service training to other professionals involved with the child on both a formal and informal basis.

Interface/Liaison with Other Professionals:

1 Joint assessment, planning and intervention is seen as essential to meet the needs of the child.

2 Assessment will include non-verbal functioning. As appropriate, this will include the findings of other professionals such as educational psychologists, clinical medical officers and health visitors. The therapist should acknowledge the value of discussion with such professionals, in addition to exchanging written information.

3 The programme of intervention for the child may be seen as the joint responsibility of therapist, parents/carers, child and other professionals, although it will be facilitated by the speech and language therapist.

4 The programme of intervention for the school aged child will be seen as a part of his/her total educational programme, most of which will be determined by other professionals and parents/carers.

5 The programme will be seen as cross curricular and functions will be relevant to all professionals involved.

6 Speech and language therapy advice will be part of the statementing/recording process for any language disordered child on whom a statement/record is completed.

The role of speech and language therapists in the education of pupils with special educational needs

---

Postal questionnaire to: speech and language therapy managers

The research project

This research project is a two year study funded by the Scottish Office Education Department, and is being carried out by a multi-disciplinary team from the Department of Education and Psychology at the University of Edinburgh and the Department of Speech Pathology and Therapy at Queen Margaret College. The team members are Ms Elizabeth Dean, Dr Morag Donaldson, Professor Robert Grieve, Ms Sally Millar, Ms Jennifer Reid, Ms Lorraine Tait, and Dr Gordon Thomson.

The project is an investigation into speech, language and communication therapy provision to children and young people with special educational needs. The project aims to: identify the extent of existing speech and language therapy provision to children and young people throughout Scotland; study models of service provision; and evaluate the extent and nature of collaboration among professionals and parents. Ultimately, your co-operation with this project will help to inform Scottish Office policy making on the provision of speech and language therapy services and professional practice.

The study is being carried out in two stages. In stage one, a set of national postal surveys will collect a range of information from professionals and parents. In stage two, researchers will visit locations of service provision to observe practice and interview parents, teachers, therapists and other professionals.

This postal survey is being sent to all speech and language therapy managers in Scotland. In addition, postal surveys designed for each group are being sent to: all speech and language therapists; principal and divisional educational psychologists in each education authority; all advisers in special educational needs; a large sample of approximately 3000 teachers in special schools, mainstream schools and nurseries; and a sample of parents. The postal surveys ask individuals in different groups to draw on their particular knowledge and experience so that an overall national picture can be obtained. In stage two, the visits and interviews will build on the data collected through the surveys and examine in depth the nature of different models of service provision and their appropriateness in different circumstances.

The questionnaire

This questionnaire aims to collect quantitative and qualitative information about your therapy service. The questionnaire is in six sections:

- **Section 1** asks about the numbers of speech and language therapists and therapy assistants employed in your service;
- **Section 2** seeks a detailed picture of the locations in your area where speech and language therapy is provided, and where therapy is not provided but is required;
- **Section 3** asks you to give the numbers of children and young people who are receiving therapy, those who are on waiting lists for therapy, and those who are awaiting assessment;
- **Section 4** invites you to describe and comment on the contact parents and voluntary organisations have with your speech and language therapy service;
- **Section 5** offers you the opportunity to comment on the provision of therapy, other issues of service provision and the unique aspects of your service that have not been covered elsewhere; and
- **Section 6** requests that you nominate locations you would like us to visit as examples of different styles of service delivery.

Throughout the questionnaire, notes to enable you to complete the survey are given before relevant questions. The research group's working definitions of relevant terms are given below.

We have tried to make the survey as easy to complete as possible. The questionnaire has been designed to elicit the information you may have available and draw on your experience in terms of professional opinion. The questionnaire should not require you to seek out additional information, although, inevitably, some of the information may not be organised in exactly the form in which you collect it. We would appreciate it if you would try to complete the survey as fully as possible, but should you find that you are asked for information you do not have, please feel free to indicate this.

The survey asks you for a range of data and comments. We have tried to produce a 'user friendly' document and, where possible, we have used tick boxes to reduce the need for lengthy responses. However, in spite of our attempts, we recognise that the document will take some time to complete, but we very much hope that you will take the time to share your information and experience with us.

All information collected will be treated in confidence; no comments will be attributed to individuals.

Definitions of terms

The following glossary is included here simply to share with you the research group's working definitions of speech, language, communication and speech, language and communication problems; these definitions are for reference only. The same glossary has been included in the questionnaires to each of the groups being surveyed and, therefore, definitions are deliberately non-technical.

Glossary

For the purposes of this survey:

A specific language or communication problem is one that interferes with learning and/or participation in the educational process, and in this sense it gives rise to special educational needs.

Communication is the process by which information, ideas and emotions are exchanged. While information and ideas are communicated primarily through language, emotions are usually communicated through touch, gesture, eye gaze, facial expression and other aspects of 'body language'. Communication is fundamental to the establishment and maintenance of relationships, and to participation in social and educational situations.

People with good speech and language can nonetheless be poor communicators, just as people with poor speech and/or language can be quite good communicators.

Language is any system of vocabulary and grammar. Such systems include speech, written words, manual signs and computer codes. Language is used for formulating thoughts and, in communication, for conveying and understanding meaning.

As language plays a fundamental role in thinking, remembering and reasoning, it is also essential for learning.

Speech is language in its spoken form. In other words, speech is not possible without language.

The ability to produce speech is not limited to physically making sounds but also includes the underlying mental processes involved in learning, remembering and reproducing the sounds of any language.

We would like to thank you in advance for your participation. If you would like to discuss the questionnaire, or require further information, please contact [illegible] at the Department of Psychology, The University of Edinburgh, 7 George Square, Edinburgh EH8 9JZ ([illegible]).

Please return the questionnaire by [illegible].

Please complete the questionnaire for your service as at 31st March 1994

Section 1

In this section we would like you to give us some information about your area of responsibility and the numbers of speech and language therapists and therapy assistants who work for your service.

1 For what area(s) are you responsible for the provision of speech and language therapy?

Health Board/Trust ______________________

NHS Trust ______________________

other ______________________

2 a) How many people in total are employed by your service as ...

speech and language therapists ☐

speech and language therapy assistants ☐

b) How many of these people provide any speech and language therapy to children (or young people under the age of 19 years)?

speech and language therapists ☐

speech and language therapy assistants ☐

- Please give numbers of people, disregard whether they are employed on a full or part-time basis
- Include all people employed at 31st March, people working, on leave, on maternity leave
- Exclude unfilled and frozen posts

3 How many people are employed by your service on a full-time basis, as ...

speech and language therapists ☐

speech and language therapy assistants ☐

- Include all people employed full-time at 31st March as per working, on leave, on maternity leave
- Exclude vacant and frozen posts

[illegible] [illegible]

[illegible] ☐

[illegible] ☐

- [illegible]
- [illegible]

[illegible] [illegible]

[illegible] ☐

[illegible] ☐

[illegible] ☐

[illegible] ☐

[illegible] ☐

[illegible] ☐

- [illegible]
- [illegible]

[illegible] [illegible]

[illegible] ☐

[illegible] ☐

- [illegible]
- [illegible]

[illegible]

[illegible] ☐

[illegible] ☐

[illegible] ☐

[illegible] ☐

[illegible] ☐

[illegible] ☐

[illegible]

[illegible]

[illegible] ☐

[illegible] ☐

[illegible] ☐

[illegible] ☐

[illegible] ☐

[illegible] ☐

BEST COPY AVAILABLE

[illegible]

[illegible]

[illegible] ☐ [illegible] ☐ [illegible]

[illegible] ☐ [illegible] ☐ [illegible]

[illegible]

[illegible] ☐ [illegible] ☐ [illegible]

[illegible] ☐ [illegible] ☐ [illegible]

[illegible]

[illegible] ☐ [illegible] ☐ [illegible]

[illegible] ☐ [illegible] ☐ [illegible]

[illegible]

[illegible] ☐ [illegible] ☐ [illegible]

[illegible] ☐ [illegible] ☐ [illegible]

[illegible] ____________________

[illegible]

[illegible] ☐

[illegible] ☐

[illegible]

[illegible] ☐

[illegible]

____

Section 2

[illegible]

[illegible]

a. [illegible]

   [illegible]

b. [illegible]

   [illegible]

   i. [illegible]

   ii. [illegible]

   iii. [illegible]

   iv. [illegible]

[illegible]

[illegible]

[illegible]

[illegible] [illegible]

[illegible] ☐
[illegible] ☐

[illegible] [illegible]

[illegible] ☐
[illegible] ☐

[illegible] [illegible]

[illegible] ☐
[illegible] ☐

[illegible]

[illegible] [illegible]

[illegible] ☐
[illegible] ☐

[illegible] [illegible]

[illegible] ☐
[illegible] ☐

[illegible]

[illegible] ☐

[illegible] ☐

[illegible]

[illegible] ☐

[illegible] ☐

[illegible]

[illegible] ☐

[illegible] ☐

[illegible]

[illegible] ☐

[illegible] ☐

[illegible]

[illegible] ☐

[illegible] ☐

[illegible]

[illegible] ☐

[illegible] ☐

- [illegible]

[illegible]

[illegible] ☐

[illegible] ☐

[illegible]

[illegible] ☐

[illegible] ☐

[illegible]

[illegible]

[illegible] ☐

[illegible] ☐

[illegible]

[illegible] ☐

[illegible] ☐

[illegible]

[illegible] ☐

[illegible] ☐

[illegible]

[illegible] ☐

[illegible] ☐

[illegible] [illegible]

[illegible] ☐
[illegible] ☐

[illegible] [illegible]

[illegible] ☐
[illegible] ☐

[illegible]

[illegible] [illegible]

[illegible] ☐
[illegible] ☐

[illegible]

[illegible] [illegible]

[illegible] ☐
[illegible] ☐

[illegible] [illegible]

[illegible] ☐

33 **Establishments run by voluntary organisations**

No. *with* on-site speech and language therapy provision ☐

No. *without and requiring* on-site speech and language therapy provision ☐

or

information not available or unsure ☐

34 Other types of establishment catering for children and young people (0 – 19 years)

No. *with* on-site speech and language therapy provision ☐

No. *without and requiring* on-site speech and language therapy provision ☐

Please give details of these establishments

193

Section 3

In this section we would like you to give us the numbers of children/young people (0 – 19) who were 'on your books' on the 31st March 1994.

35 a) As at the 31st March, how many children/young people were...

receiving speech and language therapy ☐

on review ☐

waiting for assessment ☐

waiting for speech and language therapy ☐

b) ...how many of these children have a Record of Needs?

receiving speech and language therapy ☐

on review ☐

waiting for assessment ☐

waiting for speech and language therapy ☐

36. If you have written standards on referrals, initial assessments and/or waiting lists, please, if possible, attach a copy to your completed questionnaire or outline them below.

Section 4

37 Please use this section to tell us about, and comment on, the contact parents and voluntary organisations have with your therapy service.

Section 5

In this section we would like you to describe some aspects of your service. You are asked to report on how your service has changed in relation to the Secretary of State's 1991 initiative and to outline your views on gaps and imbalances in current provision and future priorities. You are also invited to make any other comments you would like to make about your service and speech and language therapy provision generally. Please attach extra sheets as required.

38 What effects has the Secretary of State's 1991 initiative had on your service?

For example, we are interested in changes in levels of staffing and how these changes have affected the organisation of your service and the type/s of provision offered in schools. We are also interested in shifting priorities and their subsequent effects.

39 Please outline your views on strengths, gaps and imbalances in current provision and priorities for the future.

40 Please make further comments on speech and language therapy, any other issues of service provision, and the unique aspects of your service that have not been covered elsewhere (attach extra sheets are required).

Section 6

In stage two of this project the researchers will visit a range of locations to observe practice, and to interview parents, teachers, therapists and other professionals. These visits will allow us to examine in depth the models of service delivery that exist within different establishments. In order that we can best target our visits, we would like you to nominate sites that you would recommend as *examples of particular styles of service delivery*. You are invited to nominate establishments inside or outside of your own service area

Please note that we are not asking you to choose locations that you consider to provide a 'good' or a 'bad' service. We would, however, appreciate any comments you care to make about provision within each nominated location.

Please use the table below to nominate locations that you consider to be examples of *particular styles* or *models of service delivery*. In addition, **it would be useful if you would give a brief description** of how the therapy service operates in each of the locations. **Please also indicate which category** a location falls into, with reference to the categories listed on the last page of this questionnaire; these categories were also used in Section 2.

Nominated locations/schools

Name and address of school/location	Category (eg. 1 or mainstream primary school, see list overleaf)	Brief description of how service is provided and any other comments

Please nominate as many locations as you wish, continue nominations and/or comments on extra sheets as required.

Thank you for your time and co-operation.
Please now return your completed questionnaire in the envelope provided to:

Louise Tait, Department of Psychology, The University of Edinburgh, 7 George Square, Edinburgh. EH8 9JZ.

Categories of Location

Mainstream Establishments (Schools and Nurseries)

1. Mainstream primary schools
2. Mainstream secondary schools
3. Mainstream nurseries and nursery classes

Special Education (Schools, Units and Classes)

4. Special schools/units/classes for children with different levels of learning disabilities, ie. some children with severe / profound, and others with mild / moderate learning disabilities
5. Special schools/units/classes for children with mild/moderate learning disabilities
6. Special schools/units/classes for children with severe/profound learning disabilities
7. Special schools/units/classes for children with hearing impairments
8. Special schools/units/classes for children with visual impairments
9. Special schools/units/classes for children with physical disabilities
10. Special schools/units/classes for children with specific language disorders
11. Special schools/units/classes for children with pervasive communication disorders (include children on the autistic continuum
12. Special units/classes for children with emotional/behaviour difficulties
13. Psychological service department locations (not included in any of the above)

Locations in Health Board/NHS Trust premises

14. Health centres /clinics
15. Paediatric assessment units (community based)
16. Hospitals
17. Hospital assessment units
18. Hospital schools
19. Day hospitals/centres

Locations provided by Social Work Departments

20. Pre-school children's centres and other locations catering for any pre-school children

Other provision

21. Provision at home
22. Mobile therapy units
23. Charity or voluntary services
24. Other types of establishment catering from children and young people

Postal questionnaire to: speech and language therapists

The research project

This research project is a two year study funded by the Scottish Office Education Department, and is being carried out by a multi-disciplinary team from the Departments of Education and Psychology at the University of Edinburgh and the Department of Speech Pathology and Therapy at Queen Margaret College. The team members are Ms Elizabeth Dean, Dr Morag Donaldson, Professor Robert Grieve, Ms Sally Millar, Ms Jennifer Reid, Ms Louise Tait, and Dr George Thomson.

The project is an investigation into speech, language and communication therapy provision to children and young people with special educational needs. The project aims to: identify the extent of existing speech and language therapy provision to children and young people throughout Scotland; study models of service provision; and examine the extent and nature of collaboration among professionals and parents. Ultimately, your co-operation with this project will help to inform Scottish Office policy making on the provision of speech and language therapy services and professional practices.

The study is being carried out in two stages. In stage one, a set of national, postal surveys will collect a range of information from professionals and parents. In stage two, researchers will visit locations of service provision to observe practice and interview parents, teachers, therapists and other professionals.

This postal survey is being sent to all speech and language therapists in Scotland. In addition, postal surveys designed for each group are being sent to: all speech and language therapy managers; regional and divisional educational psychologists in each education authority; all advisers in special educational needs; a large sample of approximately 2000 teachers in special schools, mainstream schools and nurseries; and a sample of parents. The postal surveys ask individuals in different groups to share their particular knowledge and experience so that an overall, national picture can be obtained. In stage two, the visits and interviews will build on the data collected through the surveys and examine in depth the nature of different models of service provision and their appropriateness in different circumstances.

This questionnaire

This questionnaire aims to collect quantitative and qualitative information.

- **Section 1** asks general questions about who you work for, who you work with and how you work;
- **Section 2** invites you to describe how you work in different types of locations;
- **Section 3** asks you about in-service training;
- **Section 4** offers you the opportunity to tell us about your contact with parents and voluntary organisations;
- **Section 5** asks you to share your views on the provision of speech and language therapy.

Throughout the questionnaire, notes to enable you to complete the survey are given below relevant questions. The research group's working definitions of relevant terms are given below.

The questionnaire has been designed to elicit the information you may have available and draw on your experience in terms of professional opinion. In order to focus on *qualitative* aspects of the service you provide, the questionnaire must offer a wide range of possible responses. Therefore, you may find the format daunting at first sight, but please bear with it. We have tried the questionnaire out with a sample of therapists and we think that you will find it relatively easy to complete, once you get into it. The questionnaire should not require you to seek out additional information. We would appreciate if you would try to complete the survey as fully as possible.

The survey asks you for a range of data and comments. Where possible, we have used tick boxes to reduce the need for lengthy responses. However, we recognise that the document will take some time to complete, but we very much hope that you will take the time to share your information and experience with us.

All information collected will be treated in confidence; no comments will be attributed to individuals.

Definitions of terms

The following glossary is included here simply to share with you the research group's working definitions of *speech, language, communication* and *speech, language and communication problem*; these definitions are for reference only. The same glossary has been included in the questionnaires to each of the groups being surveyed and, therefore, definitions are deliberately non-technical.

Glossary

For the purposes of this survey:

A speech, language or communication problem is one that interferes with learning and/or participation in the educational process, and in this sense it gives rise to special educational needs.

Communication is the process by which information, ideas and emotions are exchanged. While information and ideas are communicated primarily through language, emotions are usually communicated through touch, gesture, eye gaze, facial expression and other aspects of 'body language'. Communication is fundamental to the establishment and maintenance of relationships, and to participation in social and educational situations.

People with good speech and language can nonetheless be poor communicators, just as people with poor speech and/or language can be quite good communicators.

Language is any system of vocabulary and grammar. Such systems include speech, written words, manual signs and computer codes. Language is used for formulating thought and, in communication, for conveying and understanding meanings.

As language plays a fundamental role in thinking, remembering and reasoning, it is also essential for learning.

Speech is language in its spoken form. In other words, speech is not possible without language.

The ability to produce speech is not limited to physically making sounds but also includes the underlying mental processes involved in learning, remembering and reproducing the words of any language.

We would like to thank you in advance for your participation. If you would like to discuss the questionnaire, require further information, or would like some help to complete the questionnaire, please contact Louise Tait at the Department of Psychology, The University of Edinburgh, 7 George Square, Edinburgh EH8 9JZ or tel. 031-650 3372.

Please return the questionnaire by Monday 2nd May 1994.

Please complete the questionnaire as at 31st March 1994

Section 1

1 Who employs (pays) you?
(please give the name of the Unit, Trust, Authority or other institution)

Health Board Unit ____________________

NHS Trust ____________________

Education Authority ____________________

Other, please specify ____________________

2 Do you work with any clients under 18 years old?

☐ yes

☐ no

If no, please complete the form up to this point and return the questionnaire in the enclosed SAE; you are not asked to complete any further questions. If you would like to make any comments, please turn to Section 3.

Thank you for your help, please do return the questionnaire even if you do not work with children and young people under 18.

3 In your current post, do you work as a "generalist" therapist, or a "specialist"?

☐ generalist

☐ generalist, but with specialist interest/expertise

☐ specialist

If 'specialist' or 'generalist with special interest/expertise', please state your specialism(s)/special interest(s)

____

____

4 Do you have an individual caseload or do you share a caseload with a team of speech therapists?

☐ individual caseload

☐ shared/team caseload*

- If you have a shared caseload, please complete the questionnaire only for the children for whom you have administrative responsibility. It is important that we do not count children twice. The numbers you give in the following questions will not be confused with your actual workload.

5 How many children/young people in total, within each of the following gender and age bands, are in your (administrative) caseload?

☐ boys and ☐ girls who are **pre-school** (usually 0 – 4 yrs)

☐ boys and ☐ girls at **primary** (usually 5 – 11 yrs)

☐ boys and ☐ girls at **secondary** (usually 12 – 18 yrs)

- Please answer with regard to the educational location of children/young people; you are not being asked to categorise children accurately by age. However, if children in a special school are not divided into the pre-school, primary, secondary categories please count them by age.

- Only count children and young people who are pre-school or in an educational establishment, for example, do not include young people at adult training centres.

6 Do you prioritise your caseload in any way?

☐ no

☐ yes

If yes, please describe your system of prioritisation and indicate whether there is a service policy in operation. If there is a written policy, please attach a copy to your completed questionnaire, if possible.

____

____

____

Section 2

This section of the questionnaire asks you to give us information about the children and young people you work with in different types of location, and how you work in those locations. Our aim is to collect data that will inform us, and ultimately the Scottish Office, about the diversity and complexity of the speech and language therapy services throughout Scotland.

In recognition of the existence of diverse and complex methods of service deliver, this section has been designed to elicit a wide range of responses. As such, the following pages cannot be as 'user friendly' as we would wish. Therefore, we ask that you read over the following instructions, the list of types of location, and the answer sheets before you to start to complete this section.

The following six pages are sheets of answer boxes. One sheet should be completed for, either, (a) groups of the same type of location, or (b) individual locations. Locations of the same type should be grouped together on the same answer sheet, unless you feel that the way you work in an individual location merits a separate sheet. For example, if you work in five mainstream secondary schools, and work in a similar way in three of them but quite differently in each of the other two, you may feel that it is most appropriate to fill in one sheet for three of the schools together, and then a sheet for each of the other two separately. (These instructions are repeated at the top of each of the following answer sheets. The answer sheets do not differ in any way.)

Please complete each sheet with: the type of location (see list below); the number of locations the sheet relates to; and, the number of children you work with in the location/s. For example, if you see twelve children in total in the three mainstream secondary schools used in the example above, you would enter: '2' (or write in 'mainstream secondary school'); '3' for the number of locations; and, '12' for the number of children you see in the three schools.

If you require more than six sheets please photocopy and attach extra sheets as necessary.

List of types of location (when you are filling in the answer sheets overleaf, please use the following number codes to identify different types of location)

1. Mainstream primary schools
2. Mainstream secondary schools
3. Nurseries (education) and nursery classes in mainstream schools
4. Special schools/units/classes for children with mild/moderate learning difficulties
5. Special schools/units/classes for children with severe/profound learning difficulties
6. Special schools/units/classes for children who have different levels of learning difficulties, ie. some children with severe / profound, and others with mild / moderate learning difficulties
7. Special schools/units/classes for children with hearing impairments
8. Special schools/units/classes for children with visual impairments
9. Special schools/units/classes for children with physical disabilities
10. Special schools/units/classes for children with specific language disorders
11. Special schools/units/classes for children with pervasive communication disorders
12. Special units/classes for children with behaviour difficulties
13. Psychological service department locations
14. Health centres / clinics
15. Paediatric assessment units (community based)
16. Hospitals
17. Hospital assessment units
18. Hospital schools
19. Day hospitals / centres
20. Mobile therapy units
21. Pre-school groups
22. Day nurseries, children's centres and other facilities (social work)
23. Provision at home
24. Charity or voluntary services
25. Other types of educational (not training) establishment catering for children and young people 18 years and under

BEST COPY AVAILABLE

Please complete one of these sheets for a group of locations, or individual locations in which you work. Group the same types of location together on one sheet, unless you feel any individual locations merit a separate sheet. For example, if you work in five mainstream secondary schools, and work in a similar way in three of them but quite differently in each of the other two, you may feel that it is most appropriate to fill in one sheet for three of the schools together and then one sheet for each of the other two separately . We provide you with six sheets of answer boxes; if you require more, please photocopy as necessary and attach the extra sheet/s to your completed questionnaire.

Please complete the 1st column with location type (see 'list of types of location') and relevant numbers, then tick all appropriate boxes in the other columns. ***Please make any further comments overleaf.***

LOCATIONS AND CLIENTS

Type of location/s
(see types of location list)

☐

Number of location/s
(on this sheet)

☐

Total number of children/young people you treat...
(in the locations on this sheet)

☐

TYPES OF THERAPY

DIRECT THERAPY

Therapist only:

- one to one therapy, withdrawal from class ☐
- one to one therapy, in classroom ☐
- one to one therapy, in other setting ☐
- group* therapy, withdrawal from class ☐
- group* therapy, in classroom ☐
- group* therapy, in other setting ☐

Therapist and other professional/s:

- individual therapy, withdrawal from class ☐
- individual therapy, in classroom ☐
- individual therapy, in other setting ☐
- group* therapy, withdrawal from class ☐
- group* therapy, in classroom ☐
- group* therapy, in other setting ☐

INDIRECT THERAPY

- preparation of programmes and materials ☐
- liaison with parents ☐
- discussion/planning with teachers ☐
- discussion/planning with other/s ☐
- case conferences/meetings ☐
- training other staff ☐
- other, please specify ☐

* include pairs of clients

REGULARITY OF THERAPY PROVIDED

- Intensive† blocks ☐
- Non-intensive blocks ☐
- Intensive† ongoing ☐
- Regular, for a limited period (less than 6 months) ☐
- Regular (long-term, more than six months) ☐
- Intermittently, on request ☐
- Some clients on review ☐
- Other, please specify ☐

† 3 or more times per week

WORKING WITH OTHERS

DO YOU WORK...

Directly with client, with...

- nursery nurse ☐
- learning support teacher ☐
- classroom teacher ☐
- classroom auxiliary/aide ☐
- other speech therapist/s ☐
- speech therapy assistant ☐
- psychologist ☐
- occupational therapist ☐
- parent/s ☐
- other, please specify ☐

Indirectly through/with...

- nursery nurse ☐
- learning support teacher ☐
- classroom teacher ☐
- classroom auxiliary/aide ☐
- other speech therapist/s ☐
- speech therapy assistant ☐
- psychologist ☐
- occupational therapist ☐
- parent/s ☐
- other, please specify ☐

ARE PROGRAMMES CONTINUED BY OTHERS WHEN YOU ARE NOT AROUND?

- not appropriate ☐
  (eg. because I am there all the time)

Yes...

- carried out with all children ☐
- carried out with some children ☐
- sometimes, not systematically ☐
- occasionally, in special circumstances ☐

...who continues the programmes?

No...

- not carried out at all ☐

Unsure...

- don't know/unsure ☐
- other, please specify ☐

If no or unsure can you suggest overleaf why programmes may not be continued

Section 3

7. Have you provided any in-service training sessions to education staff in the past two years?

☐ no
☐ yes

Any comments

____

____

8. Have you attended any in-service sessions together with education staff in the past two years?

☐ no
☐ yes

If yes, please comment on how useful, or not, you found the sessions

____

____

Section 4

Please use the space below to describe and comment on the contact you have with parents and voluntary organisations.

Section 5

Please use the space below to make any further comments on the provision of speech, language and communication therapy. (Please attach extra sheets if required)

Thank you for your time and co-operation in completing this questionnaire. Please return it, with any attachments, to:
Louise Tait at the Department of Psychology, The University of Edinburgh, 7 George Square, Edinburgh. EH8 9JZ.

The role of speech and language therapists in the education of pupils with special educational needs

---

Postal questionnaire to: class teachers and learning support teachers

The research project

This research project is a two year study funded by the Scottish Office Education Department, and is being carried out by a multi-disciplinary team from the Departments of Education and Psychology at the University of Edinburgh and the Department of Speech Pathology and Therapy at Queen Margaret College. The team members are Ms Elizabeth Dean, Dr Morag Donaldson, Professor Robert Grieve, Ms Sally Millar, Ms Jennifer Reid, Ms Louise Tait, and Dr George Thomson.

The project is an investigation into speech, language and communication therapy provision to children and young people with special educational needs. The project aims to: identify the extent of existing speech and language therapy provision to children and young people throughout Scotland; study models of service provision; and examine the extent and nature of collaboration among professionals and parents. Ultimately, your co-operation with this project will help to inform Scottish Office policy making on the provision of speech and language therapy services and professional practices.

The study is being carried out in two stages. In stage one, a set of national, postal surveys will collect a range of information from professionals and parents. In stage two, researchers will visit locations of service provision to observe practice and interview parents, teachers, therapists and other professionals.

This postal survey is being sent to a large sample of approximately 2000 teachers in special schools, mainstream schools and nurseries throughout Scotland. In addition, postal surveys designed for each group are being sent to: all speech and language therapists; all speech and language therapy managers; regional and divisional educational psychologists in each education authority; all advisers in special educational needs; and a sample of parents. The postal surveys ask individuals in different groups to share their particular knowledge and experience so that an overall, national picture can be obtained. In stage two, the visits and interviews will build on the data collected through the surveys and examine in depth the nature of different models of service provision and their appropriateness in different circumstances.

This questionnaire

This questionnaire aims to collect quantitative and qualitative information. The questionnaire is in three sections:

- **Section 1** asks for details of your teaching situation and for the numbers of children/young people in your class/es, or with whom you worked, in the Spring 1994 term, who had contact with a speech and language therapist;

- **Section 2** invites you to describe your contact with speech and language therapists, if any, and to consider what type of relationships with speech and language therapists you think would be most beneficial; and

- **Section 3** offers you the opportunity to make any further comments you would like us to consider.

Throughout the questionnaire, notes to enable you to complete the survey are given below relevant questions. The research group's working definitions of relevant terms are given below.

We have tried to make the survey as easy to complete as possible. The questionnaire has been designed to elicit the information you may have available and draw on your experience in terms of professional opinion. The questionnaire should not require you to seek out additional information, although, inevitably, some of the information may not be requested in exactly the form in which you collect it. We would appreciate if you would try to complete the survey as fully as possible, but should you find that you are asked for information you do not have, please feel free to indicate this.

The survey asks you for a range of data and comments. We have tried to produce a 'user friendly' document and, where possible, we have used tick boxes to reduce the need for lengthy responses. However, in spite of our attempts, we recognise that the document will take some time to complete, but we very much hope that you will take the time to share your information and experience with us.

All information collected will be treated in confidence; no comments will be attributed to individuals.

Definitions of terms

The following glossary is included here simply to share with you the research group's working definitions of *speech, language, communication* and *speech, language and communication problem*; these definitions are for reference only. The same glossary has been included in the questionnaires to each of the groups being surveyed and, therefore, definitions are deliberately non-technical.

Glossary

For the purposes of this survey:

A speech, language or communication problem is one that interferes with learning and/or participation in the educational process, and in this sense it gives rise to special educational needs.

Communication is the process by which information, ideas and emotions are exchanged. While information and ideas are communicated primarily through language, emotions are usually communicated through touch, gesture, eye gaze, facial expression and other aspects of 'body language'. Communication is fundamental to the establishment and maintenance of relationships, and to participation in social and educational situations.

People with good speech and language can nonetheless be poor communicators, just as people with poor speech and/or language can be quite good communicators.

Language is any system of vocabulary and grammar. Such systems include speech, written words, manual signs and computer codes. Language is used for formulating thought and, in communication, for conveying and understanding meanings.

As language plays a fundamental role in thinking, remembering and reasoning, it is also essential for learning.

Speech is language in its spoken form. In other words, speech is not possible without language.

The ability to produce speech is not limited to physically making sounds but also includes the underlying mental processes involved in learning, remembering and reproducing the words of any language.

We would like to thank you in advance for your participation. If you would like to discuss the questionnaire, or require further information, please contact Louise Tait at the Department of Psychology, The University of Edinburgh, 7 George Square, Edinburgh EH8 9JZ or tel. 031-650 3372.

Please return the questionnaire by Monday 2nd May, 1994.

***Class teachers*, please complete the questionnaire with regard to children/ young people who were registered in your class/es during the Spring term, January to March 1994.**

***Learning support teachers*, please complete the questionnaire with regard to children/young people with whom you worked in the Spring term, January to March 1994.**

Section 1

In this section we would like you to give us some details about your teaching situation and the numbers of children/young people in your class/es, or children/young people with whom you worked, who received speech and language therapy in the Spring term.

Please note: no information will be attributed to an individual or a particular school.

1 In what type of setting do you teach?
(Please tick/complete all applicable)

☐ mainstream nursery school or nursery class attached to a primary school

☐ mainstream primary school

☐ mainstream secondary school

☐ special school/unit/class for children with learning difficulties

☐ special school/unit/class for children with hearing impairments

☐ special school/unit/class for children with visual impairments

☐ special school/unit/class for children with physical disabilities

☐ school/unit/class for children with language disorder

☐ unit/class for children with behaviour difficulties

☐ school/unit/class for children with pervasive communication disorders
(include those classes for children on the autistic continuum)

☐ other,

please specify ______________________________

____

2 **Please indicate whether you are a learning support teacher OR which stage/s you teach**
(Please tick/complete all applicable)

☐ learning support teacher, primary
☐ learning support teacher, secondary

☐ nursery
☐ primary 1
☐ primary 2
☐ primary 3

☐ primary 4
☐ primary 5
☐ primary 6
☐ primary 7

☐ special classes or multiple stages/mixed classes, please specify ____________________

____

☐ other, please specify ____

3 How many children/young people *in total* are in your class/es or, in respect of learning support teachers, how many children/young *in total* do you work with?

☐ boys and ☐ girls

4 As far as you know, how many of *these* children/young people are currently receiving speech and language therapy?
(include all children/young people who receive therapy or other support from a therapist)

☐ boys and ☐ girls

5 Are there any other children/young people in your class/es (or with whom you work) who you think would benefit from speech and language therapy?

☐ yes ☐ no ☐ unsure

If yes, how many other children in your class do you think would benefit from speech and language therapy?

☐ 1 – 5 ☐ 6 – 10 ☐ more than 10 ☐ unsure

any comments ____

____

- **If your answer to Q4 was no children, please go to Section 3 (page 11).**

6 ***How many*** **of the children/young people in your class/es, or with whom you work, who received speech and language therapy from a therapist during the Spring 1994 term, had or have therapy as described below?**

(if any children had or have a combination of different types of therapy, count them in each category that applies)

Numbers of children

Regular speech and language therapy

☐ …children receive *regular, one-to-one* speech and language therapy *in the classroom* (on a weekly or monthly basis)

☐ …children receive *regular* speech and language therapy *in a group in the classroom* (on a weekly or monthly basis)

☐ …children receive *regular* speech and language therapy *in the school* but not in the classroom (on a weekly or monthly basis)

☐ …children receive *regular* speech and language therapy *outside the school*, for example, at a clinic (on a weekly or monthly basis)

Occasional speech and language therapy

☐ …children *occasionally* receive *one-to-one* speech and language therapy *in the classroom*

☐ …children *occasionally* receive speech and language therapy *in a group in the classroom*

☐ …children *occasionally* receive speech and language therapy *in the school* but not in the classroom

☐ …children *occasionally* receive speech and language therapy *outside the school*, for example, at a clinic

Unknown or other pattern/s of speech and language therapy

☐ …children receive speech and language therapy but you are unsure, or do not know, about the pattern of the therapy they receive

☐ …children receive speech and language therapy in some other way

please comment

____

____

Section 2

In this section we would like you to tell us about the contact you have with speech and language therapists, if any, with regard to the children/young people in your class/es, or the children/young people with whom you worked, during the Spring 1994 term.

7 Please indicate which of the following describes the type/s of personal, one-to-one contact you have with speech and language therapists in a professional context
(please tick/complete all applicable)

☐ no one-to-one contact now or in the past
☐ no current one-to-one contact, but there has been in the past
☐ regular, timetabled, one-to-one contact with therapist
☐ regular but informal contact, for example, during breaks or at the end of the day
☐ occasional one-to-one contact at your request
☐ occasional one-to-one contact at the request of a therapist

☐ other, please specify ______________________________

8 Which of the following patterns of in-service training have you been involved in?
(please tick/complete all applicable)

☐ in-service training session/s delivered by you or other education staff to speech and language therapists
☐ in-service training session/s delivered by a speech and language therapist
☐ in-service training session/s delivered by others and attended jointly by you and speech and language therapist/s

OR

☐ *not* been involved in in-service training that included speech and language therapist/s

any comments…

9 **Which of the following is included in your current personal contact with a speech and language therapist?**
(please tick/complete all applicable)

☐ not applicable, have no contact at present with a speech and language therapist

Reporting and feedback

☐ you report and give feedback (verbal or written) to the speech and language therapist on educational programme and/or assessment

☐ speech and language therapist reports and gives feedback (verbal or written) to you on therapy assessment results and progress

Observation

☐ therapist has observed classroom work

☐ you have observed therapist working with child/ren

Joint work and joint planning

☐ you and therapist work together in the classroom with individuals or groups of children

☐ you and therapist plan together educational programmes (or part of programme)

☐ you and therapist plan together speech and language therapy programmes (or part of programme)

Guidance and advice

☐ you offer guidance/advice to speech and language therapist

☐ speech and language therapist offers you guidance/advice

☐ other, please specify ______________________________

10 Ideally, what personal contact with speech and language therapists would you prefer?
(please tick/complete all applicable)

☐ no change, contact with speech and language therapist is satisfactory

☐ type of contact is satisfactory but would like more time and/or greater number of meetings

☐ type of contact is satisfactory but would like less time and/or fewer number of meetings

☐ more formal arrangements for liaison with speech and language therapist/s

☐ more formally allocated time for liaison with speech and language therapist/s

☐ a different type of contact, please specify

____

BEST COPY AVAILABLE

11 **Please indicate your involvement in multi-professional meetings concerning children/young people with speech, language and communication problems**
(please tick/complete all applicable)

☐ do not attend multi-professional meetings

☐ attendance at future needs meetings

☐ attendance at case conferences

☐ attendance at review meetings

☐ other, please specify ______________________________

If you have had any such contact with speech and language therapists and others, please specify who, in addition to yourself and a speech and language therapist, has been involved in any of the meetings (eg. child, parent, educational psychologist). Please give this information separately for each type of meeting.

____

____

12 What factors affect your contact with speech and language therapists?
(please tick/complete all applicable)

☐ you do not have the time to spend with speech and language therapists

☐ not invited by speech and language therapist to have contact

☐ speech and language therapist does not have the time to spend with you

☐ not invited to some/any meetings

☐ invited but do not have the time to attend some/any meetings

☐ do not have (or have been refused) permission to spend time out of the classroom for such contact or meetings

☐ do not feel it is an appropriate way to spend time

☐ not necessary, as another member of staff liaises with speech and language therapist/s and/or attends meetings

☐ other, please specify ______________________________

13 **Are classroom assistants, such as nursery nurses, team teachers, auxiliaries and voluntary aides (including parents working in the classroom), involved with speech and language therapy programmes?**

☐ there are *no* classroom assistants

☐ there are (one or more) classroom assistants *but* no speech and language therapy programmes

☐ there are (one or more) classroom assistants but they are *not* involved with existing speech and language therapy programmes

☐ there are (one or more) classroom assistants and they *are* involved with one or more of the existing speech and language therapy programmes

☐ classroom assistants have *previously* been involved with speech and language therapy programmes but not at present

☐ other, please specify ____________________________

14 Do you have contact with parents with regard to their child's speech and language therapy programme?

☐ yes

☐ no

any comments...

15 **Please indicate which of the following options you think would be beneficial for children in your class with speech, language and communication problems**

ref.

(a) ☐ *official* encouragement to teachers to give priority to liaison and work with speech and language therapist/s

(b) ☐ more speech and language therapy *outside* the classroom

(c) ☐ more support from speech and language therapist/s for children *in the classroom*

(d) ☐ more *joint planning* by teachers and speech and language therapists

(e) ☐ more *collaborative work* in the classroom between teachers and speech and language therapists

(f) ☐ more *training* for speech and language therapists about education in schools and the curriculum

(g) ☐ more *training* for teachers about speech, language and communication

(h) ☐ more *joint training* for teachers and speech and language therapists

(i) ☐ more involvement of teachers in the *development of curriculum-based speech and language therapy programmes*

(j) ☐ more involvement of speech and language therapists in *curriculum development programmes*

(k) ☐ more information for teachers about the speech and language therapy *service* and how the service relates to specific schools

(l) ☐ more classroom assistants dedicated to supporting children with speech and language problems

(m) ☐ more *classroom assistants* generally

(n) ☐ teachers being able to attend some/more *meetings* about individual children and young people with speech, language and communication problems, meetings such as case conferences and future needs meetings

(o) ☐ other 1, please specify______________________________

____

(p) ☐ other 2, please specify______________________________

____

Please indicate the *three* options you think should receive the highest priority.
(List these options by using the reference letters a - p.)

I think the *three* options that should receive highest priority are... ____________________

Section 3

Please use the space below to make any further comments on the provision of speech and language therapy that you would like us to consider.

Thank you for your time and co-operation.
Please now return your completed questionnaire in the envelope provided to:

Louise Tait, Department of Psychology, The University of Edinburgh, 7 George Square, Edinburgh. EH8 9JZ.

The role of speech and language therapists in the education of pupils with special educational needs

---

Postal questionnaire to: advisers in special educational needs

The research project

This research project is a two year study funded by the Scottish Office Education Department, and is being carried out by a multi-disciplinary team from the Departments of Education and Psychology at the University of Edinburgh and the Department of Speech Pathology and Therapy at Queen Margaret College. The team members are Ms Elizabeth Dean, Dr Morag Donaldson, Professor Robert Grieve, Ms Sally Millar, Ms Jennifer Reid, Ms Louise Tait, and Dr George Thomson.

The project is an investigation into speech, language and communication therapy provision to children and young people with special educational needs. The project aims to: identify the extent of existing speech and language therapy provision to children and young people throughout Scotland; study models of service provision; and examine the extent and nature of collaboration among professionals and parents. Ultimately, your co-operation with this project will help to inform Scottish Office policy making on the provision of speech and language therapy services and professional practices.

The study is being carried out in two stages. In stage one, a set of national, postal surveys will collect a range of information from professionals and parents. In stage two, researchers will visit locations of service provision to observe practice and interview parents, teachers, therapists and other professionals.

This postal survey is being sent to all advisers in special educational needs. In addition, postal surveys designed for each group are being sent to: all speech and language therapists; all speech and language therapy managers; regional and divisional educational psychologists in each education authority; a large sample of approximately 2000 teachers in special schools, mainstream schools and nurseries throughout Scotland; and a sample of parents. The postal surveys ask individuals in different groups to share their particular knowledge and experience so that an overall, national picture can be obtained. In stage two, the visits and interviews will build on the data collected through the surveys and examine in depth the nature of different models of service provision and their appropriateness in different circumstances.

This questionnaire

This questionnaire aims to collect quantitative and qualitative information. The questionnaire is in six sections:

- **Section 1** requests details of your remit, with regard to speech, language and communication;
- **Section 2** invites you to describe and comment on the teaching provision in your area/division for children and young people with speech, language and communication problems;
- **Section 3** asks you to consider the in-service training that is available in your area/division;
- **Section 4** asks you about the relationship you have with the speech and language therapy service;
- **Section 5** asks about the contact you have with parents and voluntary organisations; and
- **Section 6** offers you the opportunity to make any further comments you would like us to consider.

Throughout the questionnaire, notes to enable you to complete the survey are given below relevant questions. The research group's working definitions of relevant terms are given below.

We have tried to make the survey as easy to complete as possible. The questionnaire has been designed to elicit the information you may have available and draw on your experience in terms of professional opinion. The questionnaire should not require you to seek out additional information, although, inevitably, some of the information may not be requested in exactly the form in which you collect it. We would appreciate if you would try to complete the survey as fully as possible, but should you find that you are asked for information you do not have, please feel free to indicate this.

The survey asks you for a range of data and comments. We have tried to produce a 'user friendly' document and, where possible, we have used tick boxes to reduce the need for lengthy responses. However, in spite of our attempts, we recognise that the document will take some time to complete, but we very much hope that you will take the time to share your information and experience with us.

All information collected will be treated in confidence; no comments will be attributed to individuals.

Definitions of terms

The following glossary is included here simply to share with you the research group's working definitions of *speech, language, communication* and *speech, language and communication problem*; these definitions are for reference only. The same glossary has been included in the questionnaires to each of the groups being surveyed and, therefore, definitions are deliberately non-technical.

Glossary

For the purposes of this survey:

A speech, language or communication problem is one that interferes with learning and/or participation in the educational process, and in this sense it gives rise to special educational needs.

Communication is the process by which information, ideas and emotions are exchanged. While information and ideas are communicated primarily through language, emotions are usually communicated through touch, gesture, eye gaze, facial expression and other aspects of 'body language'. Communication is fundamental to the establishment and maintenance of relationships, and to participation in social and educational situations.

People with good speech and language can nonetheless be poor communicators, just as people with poor speech and/or language can be quite good communicators.

Language is any system of vocabulary and grammar. Such systems include speech, written words, manual signs and computer codes. Language is used for formulating thought and, in communication, for conveying and understanding meanings.

As language plays a fundamental role in thinking, remembering and reasoning, it is also essential for learning.

Speech is language in its spoken form. In other words, speech is not possible without language.

The ability to produce speech is not limited to physically making sounds but also includes the underlying mental processes involved in learning, remembering and reproducing the words of any language.

We would like to thank you in advance for your participation. If you would like to discuss the questionnaire, or require further information, please contact Louise Tait at the Department of Psychology, The University of Edinburgh, 7 George Square, Edinburgh EH8 9JZ or tel. 031-650 3372.

Please return the questionnaire by Monday 2nd May 1994.

Please complete the questionnaire with regard to your area or division as at the 31st March, 1994.

Section 1

In this section we would like you to give us some details about your remit, with regard to speech, language and communication. Even if speech, language and communication are not within your remit, please do complete the questionnaire and return it.

Please note: no information will be attributed to an individual or a particular area/division.

1 Are speech, language and communication problems part of your remit as an adviser in special educational needs?

☐ yes
☐ no

any comments ____

____

____

2 Please indicate which one of the following statements best describes the policy position within your area/division, with regard to speech, language and communication

☐ there is *no policy statement or informal policy in operation* that covers speech, language and communication problems

☐ there is *a formal, written policy statement* that includes direction on provision for children and young people with speech, language and communication problems

☐ there is *an informal, operational policy* that is not formally documented, which covers provision for children and young people with speech, language and communication problems

Please describe any policies that relate to speech, language and communication and/or attach regional or other relevant policy statements to your completed questionnaire, if possible; please note, we *are* interested in policies that relate to the speech, language or communication problems of any child with a special educational need, not just children with specific language and communication problems.

Section 2

In Section 2 we request that you describe and comment on the teaching provision in your area/division for children and young people who have speech, language and communication problems.

1 Please indicate which of the following are available within your area/division (please tick/complete all applicable)

☐ curriculum development projects *relating to speech, language and communication*

☐ school based initiatives *relating to speech, language and communication*

☐ use of information technology *relating to speech, language and communication*

☐ outreach teaching and support initiatives *relating to speech, language and communication*

☐ other initiatives *relating to speech, language and communication*

please specify ____

____

If you have ticked any of the above, please tell us about them. Please include: to whom they are available; variations between different schools/locations; and provisions that are made periodically but are not currently available.

Alternatively, please comment on the absence of such activities.

Section 3

In this section we ask you to consider and comment on the in-service training that is available in your area/division. In-service training can be an opportunity to gain new skills, build on existing skills and collect information. It can also be an opportunity for different professionals, including teachers and speech and language therapists, to share experiences and develop relationships. In the following questions we ask you to describe the provision of in-service training in your area/division and tell us who attends and delivers training sessions.

4 In your area/division, in the last two years, has there been any provision of in-service training for teachers on speech, language and communication, and/or on speech and language therapy?

☐ yes
☐ no

If yes, *who attends* such in-service training?
(please tick/complete all applicable)

☐ class teachers
☐ learning support teachers
☐ special education teachers
☐ other, please specify ____________________

If yes, *who delivers* in-service training sessions on speech, language and communication, and/or on speech and language therapy?
(please tick/complete all applicable)

☐ teachers
☐ advisers in special educational needs
☐ educational psychologists
☐ speech and language therapists
☐ other, please specify ____________________

5 **If there has there been any provision of in-service training, in the last two years, for teachers on speech, language and communication, and/or on speech and language therapy…**

Is this, or similar, training open to speech and language therapists?

☐ yes

☐ no

If yes, can therapists attend training sessions alongside teachers?

☐ yes

☐ no

If yes, do speech and language therapists choose to attend?

☐ yes

☐ no

6 Please give brief details of the above training. You may like to tell us about older initiatives where relevant. Please attach extra sheets if required.

7 In stage two of this research project we will be visiting several schools/locations. We will investigate different models of service delivery to children and young people with speech, language and communication problems. We are also interested in innovative and/or interesting models of in-service training.

If you would like to nominate locations in your area/division as examples of various styles of service delivery, please list them below. Similarly, if you wish to nominate particular programmes of in-service training, please also give details below. Please give a brief description of the types of service your nominated locations offer to children and young people with speech, language and communication problems or the characteristics of in-service training programmes.

Section 4

In this section we would like you to consider the professional relationship you have with the speech and language therapy service, if such a relationship exists.

8 Do you have any *formal* links with the speech and language therapy service?
(please tick all applicable)

☐ yes, with speech and language therapy manager(s)
☐ yes, with individual speech and language therapist(s)
☐ no

If yes, please describe the relationship(s)

9 If you would like your relationship(s) with the speech and language therapy service to be different, please describe in what way.

OR

If you *do not* have contact with the speech and language therapy service but would like a professional relationship with the service, please describe what kind of relationship you think would be most beneficial.

Section 5

Please use this section to describe any contact you have with parents of children and young people with speech, language and communication problems. Please include any contact you have with parents' groups and voluntary organisations working in this area.

Section 6

This questionnaire has been sent to *** and *** in your Education Authority. If there are any other advisers in your Education Authority you feel we should survey, it would be much appreciated if you would fill in their details below.

Name ______________________ Address ______________________

Position ______________________ ______________________

____

____

Name ______________________ Address ______________________

Position ______________________ ______________________

____

____

Please use the space below to make any further comments on the provision of speech and language therapy that you would like us to consider. (Please attach additional sheets if required.)

Thank you for your time and co-operation.
Please now return your completed questionnaire in the envelope provided to:

Louise Tait, Department of Psychology, The University of Edinburgh, 7 George Square, Edinburgh EH8 9JZ.

The role of speech and language therapists in the education of pupils with special educational needs

Postal questionnaire to: principal educational psychologists

The research project

This research project is a two year study funded by the Scottish Office Education Department, and is being carried out by a multi-disciplinary team from the Departments of Education and Psychology at the University of Edinburgh and the Department of Speech Pathology and Therapy at Queen Margaret College. The team members are Ms Elizabeth Dean, Dr Morag Donaldson, Professor Robert Grieve, Ms Sally Millar, Ms Jennifer Reid, Ms Louise Tait, and Dr George Thomson.

The project is an investigation into speech, language and communication therapy provision to children and young people with special educational needs. The project aims to: identify the extent of existing speech and language therapy provision to children and young people throughout Scotland; study models of service provision; and examine the extent and nature of collaboration among professionals and parents. Ultimately, your co-operation with this project will help to inform Scottish Office policy making on the provision of speech and language therapy services and professional practices.

The study is being carried out in two stages. In stage one, a set of national, postal surveys will collect a range of information from professionals and parents. In stage two, researchers will visit locations of service provision to observe practice and interview parents, teachers, therapists and other professionals.

This postal survey is being sent to all regional and divisional principal educational psychologists in Scotland. In addition, postal surveys designed for each group are being sent to: all speech and language therapists, all speech and language therapy managers; all advisers in special educational needs; a large sample of approximately 2000 teachers in special schools, mainstream schools and nurseries; and a sample of parents. The postal surveys ask individuals in different groups to share their particular knowledge and experience so that an overall, national picture can be obtained. In stage two, the visits and interviews will build on the data collected through the surveys and examine in depth the nature of different models of service provision and their appropriateness in different circumstances.

This questionnaire

This questionnaire aims to collect quantitative and qualitative information about your psychological service. The questionnaire is in six sections:

- **Section 1** asks about your area/s of responsibility;
- **Section 2** requests numbers of pupils with whom your psychological service is working, and how many of these pupils have been identified as having a speech, language and communication disorder;
- **Section 3** asks you about any policies and/or guidelines your psychological service has in relation to speech and language therapy;
- **Section 4** invites you to describe the operational relationship between your psychological service and the speech and language therapy service. You are also asked about the number of speech and language therapists employed or attached to your psychological service;
- **Section 5** asks about the contact you have with parents and voluntary organisations; and
- **Section 6** gives you the opportunity to make additional comments.

Throughout the questionnaire, notes to enable you to complete the survey are given below relevant questions. The research group's working definitions of relevant terms are given below.

We have tried to make the survey as easy to complete as possible. The questionnaire has been designed to elicit the information you may have available and draw on your experience in terms of professional opinion. The questionnaire should not require you to seek out additional information, although, inevitably, some of the information may not be requested in exactly the form in which you collect it. We would appreciate if you would try to complete the survey as fully as possible, but should you find that you are asked for information you do not have, please feel free to indicate this.

The survey asks you for a range of data and comments. We have tried to produce a 'user friendly' document and, where possible, we have used tick boxes to reduce the need for lengthy responses. However, in spite of our attempts, we recognise that the document will take some time to complete, but we very much hope that you will take the time to share your information and experience with us.

All information collected will be treated in confidence; no comments will be attributed to individuals.

Definitions of terms

The following glossary is included here simply to share with you the research group's working definitions of *speech, language, communication* and *speech, language and communication problem*; these definitions are for reference only. The same glossary has been included in the questionnaires to each of the groups being surveyed and, therefore, definitions are deliberately non-technical.

Glossary

For the purposes of this survey:

A speech, language or communication problem is one that interferes with learning and/or participation in the educational process, and in this sense it gives rise to special educational needs.

Communication is the process by which information, ideas and emotions are exchanged. While information and ideas are communicated primarily through language, emotions are usually communicated through touch, gesture, eye gaze, facial expression and other aspects of 'body language'. Communication is fundamental to the establishment and maintenance of relationships, and to participation in social and educational situations.

People with good speech and language can nonetheless be poor communicators, just as people with poor speech and/or language can be quite good communicators.

Language is any system of vocabulary and grammar. Such systems include speech, written words, manual signs and computer codes. Language is used for formulating thought and, in communication, for conveying and understanding meanings.

As language plays a fundamental role in thinking, remembering and reasoning, it is also essential for learning.

Speech is language in its spoken form. In other words, speech is not possible without language.

The ability to produce speech is not limited to physically making sounds but also includes the underlying mental processes involved in learning, remembering and reproducing the words of any language.

We would like to thank you in advance for your participation. If you would like to discuss the questionnaire, or require further information, please contact Louise Tait at the Department of Psychology, The University of Edinburgh, 7 George Square, Edinburgh EH8 9JZ or tel. 031-650 3372.

Please return the questionnaire by Monday 2nd May 1994.

Please complete the questionnaire with regard to the children and young people who were 'active on your books' on 31st March 1994.

Section 1

In this section we would like you to give us some details of your administrative responsibility. This information will allow us to ensure that no omissions or errors of double counting are made. Please note, however, no information will be attributed to an individual.

1 Please give the name of your Regional Authority Psychological Service

______________________________ Authority Psychological Service

2 If your service has a Divisional/Area structure, please give the name of the Division/Area for which you are responsible

______________________________ Division/Area

3 If, in addition, you have a responsibility for a service that is not geographically determined (for example, responsibility for a particular specialism that crosses geographical boundaries), please give details

____

____

____

Section 2

In this section you are asked to provide us with figures relating to the pupils who were 'active on your books' on 31st March 1994

4 a) How many pupils, within each of the following categories, were active on your books on the 31st March?

☐ boys and ☐ girls who are **pre-school** (usually between 0 - 4)

☐ boys and ☐ girls at **primary** (usually between 5 - 11)

☐ boys and ☐ girls at **secondary** (usually between 12 - 18)

b) ...how many of *these* pupils have a Record of Needs?

☐ boys and ☐ girls who are **pre-school** (usually between 0 - 4)

☐ boys and ☐ girls at **primary** (usually between 5 - 11)

☐ boys and ☐ girls at **secondary** (usually between 12 - 18)

NOTES:

- *Please answer with regard to the educational location of children/young people: you are not being asked to categorise children accurately by age. However, if children in a special school are not divided into the pre-school, primary, secondary categories please count them by age.*
- *Only count children and young people who are pre-school or in an educational establishment: for example, do not include young people at adult training centres.*

5 a) **How many of the pupils who were active on your books on 31st March (as counted in question 4a) have been identified** *as having a speech, language or communication problem, irrespective of other identified needs or whether they have a Record of Needs?*

☐ boys and ☐ girls who are **pre-school** (usually between 0 - 4)

☐ boys and ☐ girls at **primary** (usually between 5 - 11)

☐ boys and ☐ girls at **secondary** (usually between 12 - 16)

b) ...how many of **these** pupils have a Record of Needs?

☐ boys and ☐ girls who are **pre-school** (usually between 0 - 4)

☐ boys and ☐ girls at **primary** (usually between 5 - 11)

☐ boys and ☐ girls at **secondary** (usually between 12 - 16)

c) **...and how many of these pupils** have their speech and language therapy needs specifically **mentioned in Part V of the Record?**

☐ boys and ☐ girls who are **pre-school** (usually between 0 - 4)

☐ boys and ☐ girls at **primary** (usually between 5 - 11)

☐ boys and ☐ girls at **secondary** (usually between 12 - 16)

6 **Given the difficulty in keeping such records,** *the fluidity of this information and changes in* **record keeping** (e.g. **computer databases** etc.), *how accurate do you judge the above data to be?*

I ... ☐ am very confident the data are accurate

☐ am confident the data are accurate

☐ have some reservations regarding the accuracy of the data

Section 3

In this section we are interested to know about the policy on speech and language therapy that operates in your psychological service.

7 a On the 31st March 1994, did your psychological service have a policy on the provision of speech and language therapy? Please tick the statement that most applies:

☐ yes, there is a formal, written policy statement

☐ yes, there is an informal, operational policy that is not formally documented

☐ no, there is no written policy statement or informal policy in operation; only ad hoc actions taken by individual psychologists

☐ other, please specify ______________________________

____

____

b If your service has a formal or informal policy, does this policy include guidelines on recording the amount and/or type of speech and language therapy required in Part 5 of the Record?

☐ yes

☐ no

c *If there is a formal policy statement, or an informal policy in operation in your psychological service, please attach a copy or an outline of the policy to your completed questionnaire.*

Please also attach, if possible, a copy of any Regional policy statements relating to provision for children/young people with speech, language and communication problems.

8 Does your psychological service have any other policies or guidelines that influence how an individual pupil's speech and language therapy needs are recorded in Part V of the Record?

☐ yes

☐ no

If yes, please outline the policies or guidelines below, or attach copies to your completed questionnaire.

Section 6

In Section 6 we would like you to give details about how your service operates in relation to the NHS speech and language therapy services with whom you are currently involved. In addition, you are also asked about speech and language therapists employed by, or attached to, your psychological service.

7 Please describe and comment on how your psychological service and the speech and language therapy service(s) work together. (Please attach extra sheets if required)

10 How many speech and language therapists (people not FTE posts) are directly employed by, or attached to, your psychological service? (Complete or tick boxes as appropriate)

☐ speech and language therapists employed ***or*** ☐ don't know / unsure

☐ speech and language therapists attached ***or*** ☐ don't know / unsure

11 How many full-time equivalent (FTE) speech and language therapy posts are employed by, or attached to, your psychological service? (Complete or tick boxes as appropriate)

☐ . FTE speech and language therapists employed ***or*** ☐ don't know / unsure

☐ . FTE speech and language therapists attached ***or*** ☐ don't know / unsure

12 How many full-time equivalent (FTE) speech and language therapy *vacancies* are there within, or attached to, your psychological service? (Complete or tick boxes as appropriate)

☐ . FTE speech and language therapist vacancies ***or*** ☐ don't know / unsure

13 Would you see value in more speech and language therapists being employed by, or attached to, your psychological service?

☐ yes ☐ don't know / unsure

☐ no

Please comment on why you would or would not like more speech and language therapists to be employed or attached to your psychological service.
(Note: space is provided for more general comments about the provision of speech and language therapy at the end of the questionnaire)

Section 5

We recognise you have a statutory obligation to consult with parents. Nevertheless, we would like you to describe any additional contact your service has with parents of children and young people with speech, language and communication problems. Please include any contact your service has with parents' groups and voluntary organisations working in this area.

Section 6

Please use this section to make any further comments you may have.

Thank you for your time and co-operation.
Please now return your completed questionnaire in the envelope provided to:

Louise Tait, Department of Psychology, The University of Edinburgh, 7 George Square, Edinburgh, EH8 9JZ.

The role of speech and language therapists in the education of pupils with special educational needs

---

Postal questionnaire to: parents of children with speech, language or communication difficulties

The research project

This research project is a two year study looking at the speech & language therapy and special educational needs of children and young people in Scotland. The project is being carried out by a team of researchers from the University of Edinburgh and Queen Margaret College. The team members are Ms Elizabeth Dean, Dr Morag Donaldson, Professor Robert Grieve, Ms Sally Millar, Ms Jennifer Reid, Ms Louise Tait, and Dr George Thomson. The project is being funded by the Scottish Office Education Department.

The project is being carried out in two stages. In stage one, postal surveys are being sent to parents and professionals in Scotland. In stage two, researchers will visit schools and speak to parents, teachers, therapists and other professionals.

This postal survey is being sent to parents across Scotland. Different surveys are being sent to speech and language therapists, educational psychologists, advisers in special educational needs, and teachers. The postal surveys ask people in different groups to share their knowledge and experience so that an overall, national picture can be obtained.

This questionnaire

This questionnaire asks you to tell us about your child, about your child's education and about the speech and language therapy they get (or don't get). There is also space for you to tell us about anything else we should know.

We have tried to make the survey as easy to fill in as possible. But because children and their difficulties are all different, some of the questions may not fit with what is going on with your child. If you have any difficulties filling in the questionnaire, or would like to talk about it, please feel free to contact Louise Tait on 031-650 3372.

It is very important that your experiences and views are included in this study as the information collected will feed into Scottish Office policy on speech and language therapy. We hope you will take the time to tell us about your child.

All information collected will be treated in confidence; no comments will be linked to named individuals.

We would like to thank you in advance for filling in this survey. As mentioned above, if you would like to ask questions or talk about the questionnaire, please contact Louise Tait on 031-650 3372 or write to her at the Department of Psychology, The University of Edinburgh, 7 George Square, Edinburgh EH8 9JZ.

Please return this questionnaire by Monday 10th April, 1995.

If you have already completed a questionnaire, please tick this box and return the questionnaire without filling it in. ☐

If you have more than one child with speech, language or communication difficulties please complete a form for each of your children. If you require further forms please contact Louise Tait on 031-650 3372 or at the Department of Psychology, The University of Edinburgh, 7 George Square, Edinburgh, EH8 9JZ.

Your child

First we would like you to tell us some basic information about your child and her/his speech, language or communication difficulties.

1 **What sex is your child?**

☐ female ☐ male

2 **What age is your child?**

☐ years

3 **Which of the following are part of your child's speech, language or communication difficulties? (please tick all that apply)**

MY CHILD...

- ☐ has difficulty taking part in conversation, for example, not knowing when it's her/his turn to speak or listen; not asking or answering questions properly
- ☐ does not always understand what other people say
- ☐ has difficulty in making herself/himself understood because s/he doesn't use the right words and/or in the right order
- ☐ doesn't speak clearly enough to be easily understood
- ☐ doesn't really speak much at all
- ☐ has other difficulties. Please give details ______________________

____

____

4 **How old was your child when s/he first saw a speech & language therapist?**

☐ years OR ☐ my child has not seen a speech & language therapist

5 **Have you ever been given a diagnosis or 'label' for your child's difficulties?**

- ☐ no
- ☐ yes, the diagnosis/'label' I have been given was ______________________

____

Any comments

Education

In this part of the questionnaire we would like you to tell us about the education your child is getting. If your child does not get any education at the moment, please go to Question 26.

6 **Which types of nursery(ies) or school(s) does your child go to at the moment? (please tick all that apply)**

- ☐ mainstream nursery
- ☐ mainstream primary
- ☐ mainstream secondary
- ☐ special school/class/unit for children with mixed special educational needs
- ☐ special school/class/unit for children with learning difficulties
- ☐ special school/class/unit for children with hearing impairments
- ☐ special school/class/unit for children with visual impairments
- ☐ special school/class/unit for children with physical disabilities
- ☐ special school/class/unit for children with specific language disorder/language unit
- ☐ special school/class/unit for children with autism/pervasive communication disorders
- ☐ special school/class/unit for children with emotional/behavioural difficulties
- ☐ other. Please give details, for example, residential school for children with specific language disorder, mainstream school with special resources, or visiting home teacher

7 **What are the names of these nurseries or schools? Please leave this blank if you do not want to give this information.**

Name of nursery/school	Address or Town/City

8 **If your child goes to more than one nursery or school, or only goes some of the time, how is your child's time divided between different places?**

Please fill in the table below with where you child would usually be in a normal school week.

Day of week	morning	afternoon
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		

Any comments

9 **Does getting to or from school cause you or your child any problems? For example, the length of time it takes.**

10 **Who works with your child in the classroom in a usual day or week?**
(please tick all that apply)

☐ class or nursery teacher
☐ classroom assistant
☐ nursery nurse
☐ speech & language therapist
☐ learning support teacher
☐ volunteer, for example, a parent
☐ other, please give details ______________________________

11 **In the nursery or school, who do you feel understands your child's difficulties?**
(please tick everyone who you feel understands)

☐ class or nursery teacher
☐ learning support teacher
☐ head teacher
☐ nursery nurse
☐ classroom assistant
☐ speech & language therapist
☐ no-one seems to understand my child's difficulties

Any comments

12 **Does your child have a Record of Needs?**

☐ no (please go to Question 16)
☐ yes (it would be helpful if you could have your copy of the Record in front of you as you answer the next three questions)
☐ a Record of Needs is being opened at the moment

13 **Is speech & language therapy provision mentioned anywhere in your child's Record of Needs?**

☐ no (please go to Question 16)
☐ yes
☐ not sure (please go to Question 16)

14 **How is speech & language therapy provision detailed in the Record of Needs?**
(please tick all that apply)

☐ the type of speech & language therapy is detailed
☐ the amount of speech & language therapy is detailed, for example, 'twice a week'
☐ the general requirement for therapy is detailed but not the type or the amount, for example, 'speech & language therapy as required'
☐ not sure
☐ other, please give details ______________________________

____

____

Any comments

BEST COPY AVAILABLE

15 **In which part(s) of the Record of Needs is speech & language therapy detailed?**
(please tick all that apply)

☐ in Part IIIb, the 'Summary of Impairments'
☐ in Part IV, the 'Statement of Special Educational Needs'
☐ in Part Va, 'Education Authority Services'
☐ in Part Vb, 'Other Services'
☐ other, please give details ______________________________
☐ not sure

Any comments:

16 **Does your child have an educational programme that has been designed just for her/him?**

☐ no
☐ yes
☐ not sure

Any comments:

17 **If your child has an individual educational programme, who made it up?**
(please tick all the people who took part in making up the programme)

☐ not applicable, my child does not have an individual educational programme
☐ me (or other family members)
☐ class or nursery teacher
☐ learning support teacher
☐ classroom assistant
☐ speech & language therapist
☐ other, please give details ______________________________

18 **How do you keep in contact with school staff about your child?**
(please tick all that apply)

☐ sometimes the teacher speaks to me when I take or collect my child from school
☐ at least once a week the teacher speaks to me when I take or collect my child from school
☐ I have had arranged meetings (not chats when picking child up) with my child's teacher
☐ we have a home school diary for exchange of news
☐ I attend parents' evenings
☐ other, please give details ______________________________

____

Any comments:

19 **What WRITTEN information about your child do you get from teachers/nursery/school? (please tick all that apply)**

☐ not applicable, I get no written reports
☐ written reports (report cards) each term or year
☐ other written reports, please give details ____________________

____

____

20 **Does your child use signing, symbols or a communication aid?**

☐ no (please go to Question 23)
☐ yes

21 **Are any of the staff in the nursery (class or school(s)) able to sign or is anyone familiar with the symbols or aid that your child uses?**

☐ no one is able to help my child communicate through signing, symbols or a communication aid
☐ sometimes someone is available to help my child
☐ usually someone is available to help my child
☐ not sure

Any comments (for example, is there someone who can make symbol charts or someone who can fix aids if they break down?)

22 **Do you feel your child is encouraged in the use of signing, symbols or their communication aid in nursery or school?**

☐ encouraged
☐ neither encouraged nor discouraged
☐ discouraged
☐ not sure

Any comments (for example, are any classes signed, are there symbol based materials around the classroom?)

23 **Do you think your child has enough opportunities to work alongside other children during the school day?**

☐ no
☐ yes
☐ not sure

Any comments:

24 **At the moment, what are the good things about the education your child is getting?**
(for example, small class with staff geared to my child's needs, or mixing with neighbourhood children)

25 **In what ways could your child's education be better?**

Speech and language therapy

In this section we would like you to tell us about your child's speech & language therapy. If your child is not seeing a speech & language therapist at the moment please answer Question 26 and then go to Question 40.

26 **Does your child get speech & language therapy at the moment?**

- ☐ My child gets speech & language therapy at the moment
- ☐ My child has never had speech & language therapy or seen a therapist (please go to Question 40)
- ☐ My child used to receive therapy but there are no arrangements for further assessments or therapy (please go to Question 40)
- ☐ My child does not receive therapy at the moment but has seen a therapist (please go to Question 40)

27 **How does your child get his/her speech & language therapy?**

- ☐ on his/her own
- ☐ in a group
- ☐ both on his/her own and in a group
- ☐ not sure

Any comments

28 **Where does your child get his/her speech & language therapy? (please tick all that apply)**

- ☐ in the classroom
- ☐ outside the classroom but in the school
- ☐ in a clinic (not in the school building)
- ☐ at home
- ☐ not sure
- ☐ other, please give details ____________________

____

29 **How often does your child see his/her speech & language therapist at the moment?**

- ☐ daily
- ☐ more than once a week
- ☐ weekly
- ☐ monthly
- ☐ for short periods during part of the year
- ☐ other, please give details ____________________

____

30 How long do speech and language therapy sessions last?

☐ minutes
☐ don't know
☐ not relevant because therapy is part of daily routine

31 If your child uses signing, symbols or a communication aid is the speech & language therapist skilled in its use?

☐ not applicable, my child does not use signing, symbols or a communication aid
☐ no
☐ yes
☐ not sure

Any comments:

32 How involved are you with your child's speech & language therapy?
(please tick all that apply)

☐ I take part in planning therapy, for example, I make suggestions about activities for therapy sessions
☐ I usually join in the therapy sessions
☐ I usually watch the therapy sessions
☐ I help my child with homework that the therapist sets
☐ I encourage my child to use new communication skills in everyday life
☐ other: please give details

33 Who decides what your child is working towards in therapy?
(please tick all that apply)

☐ speech & language therapist decides on her own
☐ therapist decides together
☐ therapist involves [illegible]
☐ therapist asks my child for his/her opinion
☐ other: please give details

[illegible] Does the therapist give you useful ideas for working on speech and language at home with your child?

☐ no
☐ yes
☐ not sure

Any comments:

[illegible] Do you manage to carry these out?

☐ not applicable, therapist does not give me ideas for working at home
☐ no
☐ yes

Any comments:

[illegible] How does the speech & language therapist let you know how your child is doing in therapy? (please tick all that apply)

☐ after each session the therapist explains how my child is doing
☐ regularly, at least every month the therapist explains how my child is doing
☐ regularly, at least every term the therapist explains how my child is doing
☐ sometimes but not regularly the therapist explains how my child is doing
☐ the therapist gives me written reports s/he has written for me
☐ the therapist gives me copies of written reports that s/he has written for other people, for example, the school
☐ other, please give details ____________________

____

____

37 **At the moment, what are the good things about the therapy your child is getting?**
(for example, group work encourages my child to interact with other children, or therapist is able to motivate my child to try hard)

38 **In what ways could your child's therapy be better?**

39 **Apart from your child's speech & language therapist, do you know who to contact if you are unhappy about the speech & language therapy service your child is getting?**

☐ no
☐ yes

If yes, please tell us who you would contact first

Information, training and support

40 **Do you feel included in the decisions made about your child?**

☐ no
☐ yes

Any comments

41 **Are you satisfied with the sharing of information about your child that goes on between the various professionals involved?**

☐ no
☐ yes
☐ not sure

If you are not satisfied, what do you think would improve this? ____________________

____

____

Any comments

42 **Have you had good information about your child's difficulties?**

☐ no
☐ yes
☐ not sure

Any comments

43 **Have you been invited to attend any training on communication generally, and/or on signing, symbols or communication aids?**

☐ no
☐ yes

Any comments

44 **Have there been any costs to you, for example, for training, materials or communication aids?**

☐ no
☐ yes

Any comments

45 **Have you been in touch with any parents' support groups or parents' organisations?**

☐ no
☐ yes

If yes, please tell us how they helped you and, if you wish to, tell us which groups or organisations you have been in touch with.

Your comments

66 **Is there anything else you would like to tell us about your child's speech, language or communication difficulties?**

Please use this space to tell us anything you think we should consider

In the next stage of this project we will be interviewing a few parents. If you would be happy to talk to us, please give your name, address and telephone number below.

Name(s) ____________________________

Address ____________________________

____

____________________________ Tel. No. ____________________

Information about you and your family

We would like to make sure we collect information from all sorts of different people. It would be most useful if you would give us some basic information about yourself and your family. If you are happy to give us these details, please complete the following questions.

For each question, please complete and/or tick all that apply

A. Who filled in this form? ☐ mother ☐ father ☐ other parental figure

B. Who lives in the same house as your child?

☐ mother ☐ sisters aged ____________
☐ father ☐ brothers aged ____________
☐ other adults ☐ other children aged ____________

C. What jobs do the adults in your home do? For example, clerical worker, plumber or chartered accountant.

mother ______________________ OR/BUT ☐ not in paid employment at the moment
father ______________________ OR/BUT ☐ not in paid employment at the moment
other parental figure ______________ OR/BUT ☐ not in paid employment at the moment

D. What age were you and the other adults in your home on leaving secondary school? (If you can't remember please have a guess and tick not sure)

mother ____________ years old BUT ☐ not sure
father ____________ years old BUT ☐ not sure
other parental figure ____________ years old BUT ☐ not sure

E. Did you or the other adults in your home go to college or university?

mother ☐ no ☐ yes
father ☐ no ☐ yes
other parental figure ☐ no ☐ yes

F. To what ethnic group do you and your family belong?

☐ White ☐ Black – Caribbean
☐ Indian ☐ Black – African
☐ Pakistani ☐ Black – Other. Please describe ______________________
☐ Bangladeshi
☐ Chinese ☐ Any other ethnic group, or family members in different groups.

Please describe ______________________

[illegible]

ISBN [illegible]

Further copies of this report may be obtained from:

[illegible] Project
Department of Psychology
University of Edinburgh
7 George Square
Edinburgh EH8 9JZ

[illegible]